IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1976

No. 76-300

In the Matter of
KAREN QUINLAN
An Alleged Incompetent

STEPHEN GARGER and
RICHARD GALLAGHER — **Petitioners**

v.

NEW JERSEY — **Respondent**

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

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The Petitioners STEPHEN GARGER and RICHARD GALLAGHER respectfully pray that a Writ of Certiorari issue to review the Opinion of the Supreme Court of New Jersey entered in this case of March 31, 1976, APPENDIX B. (B1-51)

OPINIONS BELOW

The Opinion of the Supreme Court of New Jersey was entered March 31, 1976, from which this review is sought, is not reported and appears in the APPENDIX B, (B1-51), the ruling of the Superior Court of New Jersey, Chancery Division, Morris County, was entered November 10, 1975, from which the appeal to Supreme Court of New Jersey was taken is reported as "Matter of Quinlan," 137 N.J. Super 230, 227, Modified (1975),and is printed in the APPENDIX A, (A1-44).

JURISDICTION

An application for an extension of time in which to file a Petition for a Writ of Certiorari was presented to Justice William J. Brennan,of the Supreme Court of the United States, who on June 22, 1976, signed an order extending the Petitioners' time to and including August 28, 1976.

Petitioners respectfully pray that this Court exercise the discretion vested in it under 28 United States Code §1254(1) and grant the Writ of Certiorari.

QUESTION PRESENTED

On March 31, 1976, the Decision and Judgment of the Supreme Court of New Jersey was entered.

This case, must be looked upon as being, without legal precedents, presents most substantial and compelling constitutional questions:

> "Does the State of New Jersey, by its Supreme Court have the right to legalize 'Euthanasia' (homicidal mercy-killlings) with immunity, and declare and authorize the 'right to die' and/or 'the right to kill,' as in the Karen Quinlan Matter, without civil or criminal responsibility?"
> APPENDIX B, (B1-51).

The central figure in this tragic case is Karen Ann Quinlan, a New Jersey resident. At the age of 22, she lies in a debilitated and allegedly moribund state at Morris View Nursing Home, Morris Plains, New Jersey, County-operated by the Morris County Welfare Board. This case has to do, in final analysis, with her life,--its continuance or cessation,--and the responsibilities, rights and duties, with regard to any fateful decision concerning it, of her family, her guardian, her doctors, the nursing home, the State through its law enforcement authorities, and finally now the Court of Justice, namely: Supreme Court of the United States, the Law of the Land.

STATEMENT OF THE CASE

The severely abbreviated narrative that follows sets forth only sufficient facts to place in their setting the issues presented by this Petition.

1. REASONS FOR GRANTING THE WRIT

A constitutional question that is related and controlling is "the legal right of the State of New

Jersey by its Supreme Court to make Declaratory Judgment, APPENDIX B, (B1-51) that usurps the power of discretion of the medical profession, society and the public interest to sustain life by all its modern wisdom and profound knowledge and without Judicial Protective Controlling Guidelines substitute its own judgment 'as to who shall live and who shall die' and further compound its hazardous error in the instant case by proclaiming the 'right to kill,' with immunity, without due and lawful process, for the future and all times."

There are other significant and momentous constitutional and legal questions, more particularly the issue that "there is no constitutional right to die" and "the right to life and preservation of it are constitutional interests of the highest order."[1] * * * * *

The following provisions of the Constitution of the United States are involved:

> AMENDMENT VIII ...nor cruel and unusual punishments inflicted.
>
> AMENDMENT XIV, Section 1: . . . nor shall any State deprive any person of life, liberty, or property, without due process of law.

Likewise, the overwhelming constitutional issues become of most serious National concern since Karen Ann Quinlan is but "symbolic" by

1 *John F. Kennedy Memorial Hospital* v.*Heston*, 58 *N.J.* 576 (1971) challenging the constitutional claims asserting no constitutional 'right to die' exists; there is a compelling State interest justifying the State's priority toward preserving human life, otherwise it would be homicide and act of "Euthanasia."

said Decision of the New Jersey Supreme Court. APPENDIX B. (B1-51), which sets most dangerous legal precedent as concerns all American citizens and the "right to life" and whether this declaration of Euthanasia[2] (with immunity) by the State of New Jersey, threatens to become the Law of the Land.

This vital medico-legal case literally crys out for review by this esteemed Highest Court, for a landmark decision, and the Petitioners and their Attorney of record are acting in good faith, in the public interest, and in the interests of justice.

The Petitioners urge most respectfully that the Court's Decision, (Supreme Court of New Jersey), APPENDIX B, (B1-51), although most exhaustive and learned, sets a dangerous precedent and contravenes every constitutional guarantee of the "right to life" and the onslaught of "Euthanasia,"[3] without due and lawful process.

2. REASONS FOR GRANTING THE WRIT

One should mention at this point the Supreme Court of New Jersey, Opinion of March 31, 1976, APPENDIX B, (B1-51) which is bound to have many ramifications in the medical profession, because of the malpractice costs swamping hospitals. Likewise, in turn problems have already developed as a result of the State of

2 Misc. Text - Black's Law Dictionary, Revised Fourth Ed. 1968, p. 654. EUTHANASIA. The act or practice of painlessly putting to death persons suffering from incurable and distressing disease. . . .

3 Symposium Issue - "Euthanasia," 27 *Baylor L. Rev.* 10, (1975).

New Jersey's "Decision" in the human transplant[4] organ donation field, regarding the heart, kidneys, et cetera, and the use of highly specialized sophisticated medical apparatus and its unique concept capabilities in sustaining human life.

Involved is the constitutionality question as when to apply human life-support systems to a patient and likewise when to consequently terminate the use of such devices under what controlling circumstances, therefore the paramount issue is a criteria of Judicial Protective Controlling Guidelines.

The Petitioners are asking for a Court Decision defining contemporary issues surrounding death in their belief to off-set the associated dilemma involved in such cases.

The Petitioners originally were concerned with the Court's Decision, APPENDIX B, (B1-51) and the threats that it imposes to the "right to live," but now they are alarmed by the reported turn of events where the "guardian father" has thwarted the Court's Decision and contravened its intentions by removing his adopted daughter Karen from Hospital care, to non-care nursing home; makes this case cry out for forthwith relief and resolution.

* * * * *

Furthermore, the Petitioners urge that this action was committed naturally to circumvent their application for a "stay of execution" to the

[4] Berman, 13 *Vill. L. Rev.* 751-754 (1968) "The Legal Problems of Organ Transplantation."

Supreme Court of the United States. (No. A-1080-'76) pending Petition for Writ of Certiorari; which stay was denied by Associate Justice William J. Brennan on June 10, 1976, since the application to the Court became moot and after the fact when father guardian Quinlan, in the dead of night on June 9, 1976, by such action of removing Karen Ann Quinlan from St. Clare's Hospital to a County Welfare Nursing Home at Morris Plains, New Jersey.

Returning again to the Court on June 21, 1976, the Human Life Amendment Group applied to the United States Supreme Court for an extension of time to file a Petition for Writ of Certiorari. That extension was granted and signed by Associate Justice Brennan, with an extension of 60 days up to and including August 28, 1976.

The Petitioners are Stephen Garger and Richard Gallagher v. the State of New Jersey, (No. A-1120-'76) in the matter of Karen Ann Quinlan, an alleged incompetent.

On March 31, 1976, the New Jersey State Supreme Court overruled the Lower Court's Decision (the Superior Court of New Jersey, Chancery Division, Morris County, was entered on November 10, 1975), APPENDIX A, (A1-44) in the Karen Ann Quinlan case. At the same time, likewise, the Supreme Court of New Jersey appointed Karen's adopted father, her guardian, APPENDIX D, (D-1), and granted him the right to remove her from the MA-1 respirator,[5] which was

[5] Bellegie, 27 *Baylor L. Rev.* 31-33 (1975) Describing the functioning of a respirator which takes over completely the breathing when the patient does not breathe spontaneously. This respiratory function can maintain a patient indefinitely, and does so on numerous occasions where it is a matter of life and death.

believed, at the time, to be sustaining her life.

In mentioning some of the highlight facts, surrounding circumstances of the case all of the Respondents in the case, to say the least, had 90 days in which to appeal the Decision and Judgment of the Supreme Court of New Jersey, which was entered on March 31, 1976, APPENDIX B, (B1-51) After 60 days had elapsed and no one having yet taken advantage of their legal right to appeal, then the Human Life Amendment Group, decided to approach the Respondents in an effort to have them do so.

They in turn sent letters to each of those Respondents but received only one reply, and that was from Thomas R. Curtin, Esq., the former guardian, Ad Litem, APPENDIX E, (E-1). Mr. Curtin informed the organization that he never received any communication from a pro-life group throughout this case. In so many words, he was asking .. . why at this late stage? The answer is obvious . . . none of the Respondents seemed to avail themselves of their appeal rights; therefore, it became necessary that the Human Life Amendment Group would have to go ahead through their Attorney and oppose the Decision of the Supreme Court of New Jersey on its own initiative.

The Petitioners are indeed compassionate of Mr. Quinlan's dilemma as to his adopted daughter Karen, but cannot condone nor do they agree with his determined desire to allow her to die, regardless of the fact, with alleged so-called words as "grace and dignity."[6]

[6] Sharp v. Craffs, 27 *Baylor L. Rev.* 86, 89 (1975) "Death with Dignity" The Physician's Civil Liability.

Now, however, he is faced with his present "disappointment" of Karen not dying as expected after she was weaned and then removed from the respirator. The reported disagreement in the past with doctors at St. Clare's Hospital,in Denville, New Jersey, because the attending physicians [7] at the Hospital were unwilling to honor to any degree the New Jersey Supreme Court Decision of March 31; 1976; APPENDIX B, (B1-51) whereby, in the doctors' opinions to remove life-saving implements such as "intravenous feeding" of "protein high calorie diets," together with "nutritional supplements," "antibiotic medication" to meet a pulmonary infection crisis and likewise preclude other "extraordinary" means in order to keep a patient alive--not contemplated by the New Jersey Court's Decision. For one to say the least is tantamount beyond question, if allowed in any sense of the word would be for the future and all times; speeding down the road to inflict "Euthanasia" with "immunity," without due and lawful process.

It should therefore be said it is the theologian's task to call attention to the moral and religious dimensions for a review of the secularistic issues and make informal judgment about them.

Furthermore, the theologians should itself be concerned with the issue dealing with the sacredness, inviolability of the "sanctity of life" its "morally offensive" and "irresponsible" steps; as human life daily threatened in many ways in

[7] Clark v. Wichman, 72 N.J. 486-493, (App. Div. 1962) Doctors'--it is the duty that establishes his legal obligation on the attending physician to his patients.

our society by inadequate laws with the proliferation of "Euthanasia."

The Petitioners might say, before going further, it should be pointed out that the use of the terms ordinary and extraordinary from the moral standpoint differs from the medical use of such terminology. When doctors use the term ordinary it is used in reference to medical practice. Whatever, would be the standard usual treatment would be considered ordinary in this sense. But moral theologians use the term in reference to the burden it may put on the patient. From this standpoint an ordinary treatment from the medical standpoint could be extraordinary from the moral standpoint. Thus, hemodialysis may be the ordinary, usual, treatment when the human kidneys, fail to function properly, but from a moral standpoint it could be an extraordinary treatment.

The outlined distinction does not necessarily coincide with the distinction between natural and artificial means. Insulin, for instance, for the patients' daily use, although artificial would be classified as an ordinary means, as well as, in the case at point, "intravenous feeding," "nutritional supplements," and use of "antibiotic medication" to prolong human life.

3. REASONS FOR GRANTING THE WRIT

Recently the Supreme Court of New Jersey ruled that the newly appointed guardian, her "adopted father," (APPENDICES B, (B1-51) and D, (D-1) could cease extraordinary treatment, if Karen were ruled to be a hopeless case. Karen,

unfortunately, has hovered in a comatose[8] state for over 14 months, but upon removal of the respirator, and to everyone's surprise, she is breathing on her own. It had been assumed that the Court's ruling of March 31, 1976, APPENDIX B (B1-51) pertained only to the use of a MA-1 respirator as an extraordinary means. It has since become quite evident that that ruling is now being interpreted to extend, as so stated to the use of feeding, antibiotics, nutritional supplements, and whatever else might be considered extraordinary.

A person or a member of a family must consider for their own protection, legalistically speaking,they cannot afford to look upon an act of consequential result "homicide" lightly--to say the least, on the subject; the decision to terminate care in certain categories of alleged hopeless cases are (shamefully, with a sense of subconsciousness after-thought, and associated with a degree of guilt) made in hospitals and medical clinics every day and listed as "clinical deaths." Therefore, one must not overlook the fact that those doctors, as well as relatives, who make decisions, may some day face criminal (homicide) charges if, by chance, their actions result in a patient's death, regardless of motive, proving sufficient grounds for conviction....

Likewise, it also appears that the Decision

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[8] *Schueler v. Strelinger*, 43 *N.J.* 330 (1964). The "Brain," the only organ incapable of transplant to date, is still, even among neuroanatomists unknown insofar as the interrelationships of some of its parts and how these parts are controlled by the central, sympathetic and autogenous automatic nervous system.

of the Supreme Court of New Jersey, APPENDIX B, (B1-51), had not been implemented by St. Clare's Hospital Ethics Committee or like body on the subject. It is reported that not until some 10 days or so after Karen Ann Quinlan had been removed from the Hospital care to the County-operated Welfare Nursing Home, which, if a fact, further compounds the issue concerned.

It is beginning also to appear at this late date that some of the Respondents are now nevertheless having some second thoughts about the significance of the Supreme Court of New Jersey decision-making--and perhaps would like to exercise their rights to appeal--since Karen is surviving the removal of the respirator--so that the death-dealing processes not become heinous abuses of law and order, as well as, our constitutional rights and liberties, fully expressed in the Eighth and Fourteenth Amendments.

Furthermore, the Petitioners conclude,--the measures recommended such as ''Controlled Guidelines,'' carry the reasonable hope of conferring some benefit to the Nation, and none of them has a cost that approaches the cost of inaction.

CONCLUSION

The basic fundamentals upon which this Petition applying for a Writ of Certiorari is based is that a crying need for Judicial Controlling Guidelines from this Court applicable to comatose patients at a crucial time, which represents a National issue of great magnitude in the public interest. Such a type as this issue be resolved whether applicable to Medical Device Safety Act, et cetera, or the ''symbolic'' indeed unfortunate Karen Ann Quinlan Matter,--New Jersey Court's landmark ''right to die'' Decision Case. The Court, in its judicial wisdom, should take a second look at the legal reasons and principles upon which the decision is based, as the ''Opinion'' of the Supreme Court of New Jersey on March 31, 1976, APPENDIX B, (B1-51)), so-stated it was a''Modified and remanded'' type of case.

The case at point is to avoid a denial of due process of law under the Eighth and Fourteenth Amendments of the Constitution of the United States. Thereby, affording some future Judicial Protective Controlling Guidelines to cover any unfortunate comatose individual under those Amendments. Because, we cannot lose sight of the fact, whatever the cause--we are now confronted with the reality, that the ''Euthanasia'' road is 'too tempting.'

Therefore, the most frightening thing about the ''right to die'' Decision is in the last paragraph, APPENDIX B, (B1-51) regarding the elucidated wording used in the ''Opinion'' of the Supreme Court of New Jersey, whereby, it extends this decision to all those considered as being

unfortunate individuals in like future circumstances

> "By the above ruling we do not intend to be understood as implying that a proceeding for judicial declaratory relief is necessarily required for the implementation of comparable decisions in the field of medical practice."

This petition for a Writ of Certiorari should therefore be granted forthwith.

Respectfully submitted

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Attorney for Petitioners

CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of August, 1976, three (3)-copies of the Petition for Writ of Certiorari were served upon Respondent by depositing same in the United States Mail, postage prepaid in an envelope addressed to the Honorable William F. Hyland, Attorney General of New Jersey, State House Annex, Trenton, New Jersey #08625. I further certify that all parties required to be served have been served.

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APPENDIX

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION
MORRIS COUNTY

IN THE MATTER OF KAREN QUINLAN, :

AN ALLEGED INCOMPETENT. :

Docket No. C-201-75 Decided: November 10, 1975

OPINION

Mr. Paul W. Armstrong argued the cause for Petitioners Joseph and Julia Quinlan; Mr. James M. Crowley of the New York Bar of Counsel. (Mr. Armstrong and Mr. Crowley on the briefs)

Mr. Daniel Coburn, Guardian Ad Litem, argued the cause for Karen Quinlan, An Alleged Incompetent. (Mr. Coburn, Ms. Astrid Baumgardner, Ms. Leslie Obus, Mr. Drew Kastner, Mr. Bruce Shaine, Legal Assistants, on the brief)

Mr. William F. Hyland, Attorney General of New Jersey, and Mr. David S. Baime, Chief, Appellate Section, argued the cause for the Defendant State of New Jersey, Mr. John De Cicco, First Assistant, Appellate Section, of counsel and on the brief; (Mr. David S. Baime, Ms. Jane E. Deaterly, Mr. Daniel Louis Grossman, Mr. Robert E. Rochford, Ms. Helen E. Szabo and Mr. William Welaj, Deputy Attorneys General, on the briefs)

Mr. Donald G. Collester, Prosecutor of Morris County, argued the cause for Defendant County of Morris. (Mr. Collester and Mr. Bruce Chait on the brief)

Mr. Ralph Porzio, (Messrs. Porzio, Bromberg and Newman), argued the cause for Defendants Doctor Arshad Javed and Doctor Robert J. Morse. (Mr. Porzio on the brief)

Mr. Theodore E. B. Einhorn, argued the cause for the Defendant St. Clare's Hospital. (Mr. Einhorn on the brief)

MUIR, J.S.C.

In his initial pleading, Joseph Quinlan, father of 21-year old Karen Ann Quinlan, seeks, on grounds of mental incompetency, to be appointed the guardian of the person and property of his daughter. He alleges her "vital processes are artificially sustained via the extraordinary means of a mechanical MA-1 Respirator." He imprecates the Court grant "the express power of authorizing the discontinuance of all extraordinary means of sustaining the vital processes of his daughter."

By a pleading amendment he also seeks to restrain the Morris County Prosecutor, Karen Quinlan's attending and treating physicians and St. Clare's Hospital from interfering with the exercise of the authorization sought and to enjoin the Prosecutor from prosecuting for homicide when the authorization sought is effected.

The Court pursuant to Rule 4:26-2 appointed Daniel Coburn, Esq. guardian ad litem.

At the pretrial conference held on the return date of an order to show cause issued with the amended pleading, the State of New Jersey through the Attorney General intervened.

Plaintiff initially asserted that Karen Quinlan is legally and medically dead but altered this position prior to trial by admitting she is not dead "according to any legal standard recognized by the State of New Jersey." Brief for Plaintiff at 29.

It is stipulated by all parties tnat Karen Ann Quinlan is unfit and unable to manage her own affairs.

The Court's findings of fact are as hereinafter set forth:

Karen Ann Quinlan, one of three children of Joseph and Julia Quinlan, was born April 24, 1954.

She was baptized and raised a Roman Catholic. She attended Roman Catholic Church affiliated elementary and secondary schools. She is a member of her parents' local Roman Catholic Church in Mount Arlington, New Jersey. The parish priest is Father Thomas A. Trapasso.

Sometime in late 1974 or early 1975, Karen Quinlan moved from her parents' home. Thereafter, she had at least two subsequent residences, with the last being a lake cottage in Sussex County, New Jersey.

On the night of April 15, 1975, friends of Karen summoned the local police and emergency rescue squad, and she was taken to Newton Memorial Hospital. The precise events leading up to her admission to Newton Memorial Hospital are unclear. She apparently ceased breathing for at least two fifteen minute periods. Mouth to mouth resuscitation was applied by her friends the first time and by a police respirator the second time. The exact amount of time she was without spontaneous respiration is unknown.

Upon her admission to Newton Memorial, urine and blood tests were administered, which indicated the presence of quinine, aspirin, barbiturates in normal range and traces of valium and librium. The drugs found present were indicated by Dr. Robert Morse, the neurologist in charge of her care at St. Clare's, to be in the therapeutic range and the quinine consistent with mixing in drinks like soda water.

The cause of the unconsciousness and periodic cessations of respiration is undetermined. The interruption in respiration apparently caused anoxia - insufficient supply of oxygen in the blood - resulting

in her present condition.

Hospital records at the time of admission reflected Karen's vital signs to be normal, a temperature of 100, pupils unreactive, unresponsivity to deep pain, legs rigid and curled up with decorticate brain activity. Her blood oxygen level was low at the time. She was placed upon a respirator at Newton Hospital.

At 10 p.m. on April 16, 1975, Dr. Morse examined Karen at the request of her then attending physician. He found her in a state of coma with evidence of decortication indicating altered level of consciousness. She required the respirator for assistance. She did not trigger the respirator, which means she did not breathe spontaneously nor independently of it at any time during the examination. Due to her decorticate posturing, no reflexes could be elicited.

In the decorticate posturing, the upper arms are drawn into the side of the body. The forearms are drawn in against the chest with the hands generally at right angles to the forearms, pointing towards the waist. The legs are drawn up against the body, knees are up, feet are in near the buttocks and extended in a ballet type pose.

He found her oculocephalic and oculovestibular reflexes normal. The oculocephalic reflex test consists of turning the head from side to side with the eyes open. In a positive response, when the head is rotated to the right, the eyes deviate to the left. As part of this test the head is also moved front and back, the neck is flexed in the back movement, causing the eyelids to open. This phenomenon is called "doll's - eyelid response". (Dr. Morse found that reflex intact on April 26th according to hospital records.) The oculovestibular reflex ascertained by a

caloric stimulation test consists of the slow introduction of ice water into the ear canal. The eyes drift or move toward the irrigated ear. It is a lateral eye movement test.

He also found pupillary reaction to light in both eyes.

Her weight at the time was 115 pounds

Dr. Morse could not obtain any initial history (i.e., the circumstances and events occurring prior to Karen's becoming unconscious). There was no information available from her friends. He speculated at the outset on the possibility of an overdose of drugs, past history of lead poisoning, foul play, or head injury due to a fall. He indicated that the lack of an initial history seriously inhibits a diagnosis.

Karen was transferred to the Intensive Care Unit (I.C.U.) of St. Clare's Hospital, under the care of Dr. Morse. At the time of her transfer, she was still unconscious, still on a respirator, a catheter was inserted into her bladder and a tracheotomy had been performed.

Upon entry to the St. Clare's I.C.U. she was placed on a MA-1 Respirator, which provides air to her lungs on a controlled volume basis. It also has a "sigh volume", which is a periodic increase in the volume of air to purge the lungs of any accumulation of fluids or excretions. The machine takes over completely the breathing function when the patient does not breathe spontaneously.[1]

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1 *See* Bellegie, "Medical Technology As It Exists Today," 27 *Baylor L. Rev.* 31, 32, describing the functioning of a respirator, wherein the author states, "This apparatus can maintain a person's respiratory functions indefinitely, and does so on many occasions where it is a matter of life and death."

Subsequently, the serial blood gas or arterial blood gas examinations were made. The tests indicate the degree of acidity (pH) in the blood, the level of oxygen (pO_2) in the blood and the level of carbon dioxide (pCO_2) in the blood. The latter is indicia of the extent carbon dioxide is discharged from the lungs. The pH reflects whether there is an excess of acid (acidosis) or an insufficiency of acid (alkalosis) in the blood. I note parenthetically the blood gas tests have been conducted continuously from the time of Karen's admission to St. Clare's up to the present. There are constant references through the hospital records of pH, pO_2, pCO_2 measurements. Dr. Javed, the attending pulmonary internist, indicated some 300 tests were conducted.

Dr. Javed testified the blood tests were all normal while Karen was on the respirator.

In an effort to ascertain the cause of the coma, Dr. Morse conducted a brain scan, an angiogram, an electroencephalogram (EEG), a lumbar tap and several other tests. The first three are related to the brain and are conducted, according to the testimony, with the object of finding an injury or insult to the brain, such as a subdural hematoma or the like, or for ascertaining any abnormality in the brain activity patterns. The latter is particularly true of the EEG where electrodes are placed on the skull. The measurement is made of cortical neurons. The neuron is basically a conducting cell of nervous energy. The recordings are made on awake and sleep cycles. The awake recorded data, referred to in the testimony as alpha rhythm or activity, indicates a frequency of pattern which can be compared against normal frequencies or patterns to determine whether

any abnormality exists. The EEG establishes the existence or non-existence of normal patterns. It does not precisely locate the insult or lesion causing, in this case, the unconsciousness. Dr. Morse indicated the EEG performed at the outset established nothing abnormal for a comatose person and did not establish the offending agent to her central nervous system which caused her unconsciousness. Subsequent EEGs provided no further information. All indicated brain rhythm or activity.[2]

Subsequent tests and examinations did not further the establishment of the precise location and cause of Karen's comatose condition.

Dr. Morse testified concerning the treatment of Karen at St. Clare's. He averred she receives oral feedings since intravenous feeding is insufficient to sustain her. She is fed a high caloric nutrient called ''Vivenex'' which she receives through a small nasal gastro tube inserted in her gastro- intestinal system. He asserts this is necessary to keep her ''viable''. She has apparently lost considerable weight, being described as emaciated by most of the examining experts, who also indicate her weight condition to be good under the circumstances.

There is constant threat of infection, according to Dr. Morse. Antibiotics are administered to thwart potential infection with tests constantly being made to keep a check on this threat. The hospital records

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[2] The Court notes the descriptions of the medical terms, the medical tests, the bodily functioning and related information contained in this opinion are based upon its understanding of the testimony and terms used and are provided as a necessary essential to the opinion but are not intended to be exhaustive or medically precise.

indicate specialists consulted with respect to the cleaning, utilization and operation of the urethral catheter and with respect to the treatment and care of decubiti (lesions commonly known as bed sores) generated by her continuous repose.

The day-by-day charts entitled ''Vital Signs'', kept by nurses who give her 24-hour care indicate, in part, the following:

1. Her color was generally pale, her skin warm, she was almost constantly suffering from diaphoresis (sweating), many times profusely but occasionally moderately or not at all;

2. there was always a reaction to painful stimuli, she responded decerebrately to pain, she sometimes would grimace as if in pain,which would be followed by increased rigidity of her arms and legs;

3. there would be periodic contractions and spasms, periodic yawning, periodic movements of spastic nature;

4. pupils were sometimes dilated, sometimes normal but almost always sluggish to light;

5. body waste disposal through the urethral catheter and the bowel was indicated to occur;

6. feedings of Vivinex were given alternately with water on various nurses shifts;

7. the nurses were constantly moving, positioning, and bathing her;

8. body rashes occurred at times; decubiti were treated with heat lamps on occasions;

9. sometimes she would trigger and assist the respirator; other times she would go for periods without triggering it at all;

10. her extremities remained rigid with contraction of them being described as severe at times;

11. on May 7th, nurses indicated she blinked her eyes two times when asked to and appeared responsive by moving her eyes when talked to but there is no further evidence of this type reaction thereafter.

Dr. Javed indicated efforts were made to wean or remove Karen from the respirator. The hospital records support this. Dr. Javed testified for weaning to be successful, the patient must have a stable respiratory pattern. Karen was taken off the respirator for short periods of time. Each time, her respiratory rate, rate of breathing, went up and the volume of air intake would decrease. He indicated her breathing rate would more than double in intensity while her "tidal volume" or air intake would drop 50 percent. The longest period of time she was off the respirator was one-half hour. He further indicated during removal from the respirator her pO_2 dropped. He stated the respiratory problem is secondary to the neurological problem, and without improvement in the latter she cannot be removed from the respirator since she would be unable to maintain her vital processes without its assistance.

Dr. Morse's hospital notes indicate there is no neurological improvement from the time of her admission to St. Clare's to date. He testified Karen changed from a sleeping comatose condition to a sleep-awake type comatose condition but described this as normal in comatose patients and not any indication of improvement. During the awake cycle, she is still unconscious.

In Dr. Morse's opinion, the cause of Karen's condition is a lesion on the cerebral hemispheres and a lesion in the brain stem. In response to various questions from respective counsel, he described the

cortex of the brain as being affected with involvement of the brain stem. He indicated the lesion involves the central hemisphere as far down as the thalamus with patchy areas of the diencephalon and the respiratory centers located in the pons and medulla areas and also noted there is evidence of possible cerebral hemorrhage, sub-cortical white matter involvement, and possible involvement of the diencephalon and certain portions of the brain stem. In Dorland's *Illustrated Medical Dictionary,* 25th Edition 1965 at 365 the cortex is defined as the outer layer or thin layer of gray matter on the surface of the cerebral hemisphere, and that it reaches its highest development in man, where it is responsible for the higher mental functions, for general movement, for visceral functions, perception, and behavioral reaction, and for the association and integration of these functions. The testimony indicated white matter is located under the cortex. It also reflected a system of nerves commencing with the spine, leading through the brain stem and spreading out in network fashion through the cerebral hemispheres encompassing the white matter and cortex.

The brain stem is described as consisting of essentially three parts: the pons, the medulla oblongata, and midbrain with some authorities including the diencephalon. It is the stemlike portion of the brain that connects the cerebral hemispheres with the spinal cord. The brain stem, apparently, including the diencephalon, is the control for the respiratory functioning of the body.

In absence of a clear history, Dr. Morse relied basically upon the decorticate posturing of Karen Quinlan and the respiratory difficulty for reaching his conclusion as to the brain lesion locations. He

contrasted the decorticate posture to decerebrate posture of a patient for drawing his conclusions.

He asserted with medical certainty that Karen Quinlan is not brain dead. He identified the Ad Hoc Committee of Harvard Medical School Criteria as the ordinary medical standard for determining brain death and that Karen satisfied none of the criteria. These criteria are set forth in a 1968 report entitled "Report of the Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death": A Definition of "Irreversible Coma," 205. J.A.M.A. 85 (1968)

The report reflects that it is concerned "only with those comatose individuals who have discernible central nervous system activity" and the problem of determining the characteristics of a permanently non-functioning brain. The criteria as established are:

"1. Unreceptivity and Unresponsitivity - There is a total unawareness to externally applied stimuli and inner need and complete unresponsiveness ... Even the most intensely painful stimuli evoke no vocal or other response, not even a groan, withdrawal of a limb, or quickening of respiration.

"2. No Movements or Breathing - Observations covering a period of at least one hour by physicians is adequate to satisfy the criteria of no spontaneous muscular movement or spontaneous respiration or response to stimuli such as a pain, touch, sound or light. After the patient is on a mechanical respirator, the total absence of spontaneous breathing may be established by turning off the respirator for three minutes and observing whether there is any effort on the part of the subject to breathe spontaneously ...

"3. No Reflexes - Irreversible coma with abolition

of central nervous system activity is evidenced in part by the absence of elicitable reflexes. The pupil will be fixed and dilated and will not respond to a direct source of bright light. Since the establishing of a fixed, dilated pupil is clear-cut in clinical practice, there would be no uncertainty as to its presence. Ocular movement (to head turning and to irrigation of ears with ice water) and blinking are absent. There is no evidence of postural activity (deliberate or other). Swallowing, yawning, vocalization are in abeyance. Corneal and pharyngeal reflexes are absent.

As a rule the stretch of tendon reflexes cannot be elicited; i.e., tapping the tendons of the biceps, triceps, and pronator muscles, quadriceps and gastrocnemius muscles with reflex hammer elicits no contraction of the respective muscles. Plantar or noxious stimulation gives no response.

"4. Flat - Electroencephalogram - of great confirmatory value is the flat or isoelectric EEG....

All tests must be repeated at least 24 hours later with no change.

The validity of such data as indications of irreversible cerebral damage depends on the exclusion of two conditions: hypothermia (temperature below 90°F.) or central nervous system depressants, such as barbiturates."

Dr. Morse reflected carefully in his testimony on Karen's prognosis. He described her condition as a chronic or "persistent vegetative state". Dr. Fred Plum, a creator of the phrase, describes its significance by indicating the brain as working in two ways. "We have an internal vegetative regulation which controls body temperature, which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart

rate, which controls chewing, swallowing and which controls sleeping and waking. We have a more highly developed brain, which is uniquely human, which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think. (See Dorland's definition set forth heretofore.) Brain death necessarily must mean the death of both of these functions of the brain, vegetative and the sapient. Therefore, the presence of any function which is regulated or governed or controlled by the deeper parts of the brain which in layman's terms might be considered purely vegetative would mean that the brain is not biologically dead.''

Dr. Morse, in reflecting on the prognosis, notes Karen's absence of awareness of anything or anyone around her. In response to a direct question he noted she is not suffering from locked-in syndrome in which patient is conscious but so totally paralyzed that communications can be made only through a complex system of eye or eyelid movements.

Dr. Morse states Karen Quinlan will not return to a level of cognitive function (i.e., that she will be able to say ''Mr. Coburn I'm glad you are my guardian.'') What level or plateau she will reach is unknown. He does not know of any course of treatment that can be given and cannot see how her condition can be reversed but is unwilling to say she is in an irreversible state or condition. He indicated there is a possibility of recovery but that level is unknown particularly due to the absence of pre-hospital history.

Karen Ann Quinlan was examined by several experts for the various parties. All were neurologists with extensive experience and backgrounds. Some had done research in the area of brain injury,

conscious and comatose behavior. The qualifications of all were admitted.

On October 2, 1975, Dr. Stuart Cook, Dr. Eugene Loesser and Dr. Fred Plum, in the presence of Doctors Morse, Javed and others examined Karen. Each reviewed the medical and hospital records and talked with the attending physicians. The examination consisted in part of Karen's removal from the respirator for a 3-minute and 45-second interval and an EEG.

Their testimonies did not vary significantly. Some gave in greater detail than others. A general synopsis of their testimonies indicates they found Karen comatose, emaciated and in a posture of extreme flexion and rigidity of the arms, legs and related muscles which could not be overcome, with her joints severely rigid and deformed. During the examination, she went through awake and sleep periods but mostly awake. The eyes moved spontaneously. She made stereotyped cries and sounds and her mouth opened wide when she did so. Cries were evoked when there was noxious stimulation. She reflexed to noxious stimuli. Her pupils reacted to light and her retinas were normal. Her reflex activity, deep tendon reflexes, and plantar stimulation of soles of her feet could not be elicited because of the severe flexion contractures. She triggered the respirator during the entire examination except for the interval of removal. When she was removed from the respirator, with an oxygen catheter inserted through the traecheostomy, she breathed spontaneously and her blood gases were in normal range. Her EEG showed normal electrical activity for a sedated person. (She was sedated for the EEG). She does not have the

locked-in syndrome.

All agree she is in a persistent vegetative state. She is described as having irreversible brain damage; no cognitive or cerebral functioning; chances for useful sapient life or return of discriminative functioning are remote. The absence of knowledge on the events precipitating the condition, the fact that other patients have been comatose for longer periods of time and recovered to function as a human made Dr. Cook qualify his statement as to the return to discriminative functioning. All agree she is not brain dead by present known medical criteria and that her continued existence away from the respirator is a determination for a pulmonary internist.

Dr. Sidney Diamond examined Karen and testified on behalf of the State. There was no EEG or removal from the respirator during his examination. He reviewed her history and talked with the treating physicians. His physical observations of her conformed with those of other examining neurologists. He states Karen is not brain dead within the Harvard Criteria.

He considered "empirical data" which included Dr. Javed's weaning attempts and said he was convinced there is no evidence she can continue to exist physically without the respirator. His opinion is that no physician would interrupt the use of the respirator and that the continued use of the respirator does not deviate from standard medical practice.

Dr. Julius Korein testified as an expert on behalf of the plaintiff. There was no removal from the respirator when he examined Karen. He also reviewed medical and hospital records and talked to treating physicians. He made caloric stimulation and EEG tests.

His description of Karen's posturing, reflexes, eyes, body movements and other conditions did not vary significantly from other experts. His diagnosis of the extent and area of the brain injury or lesion - in the cerebral hemisphere with brain stem involvement - essentially agree with that of Dr. Morse. He described the upper brain area injury as a severe bilateral cerebral involvement with anoxia as the probable cause. He found a palmomental reflex, evidencing interruption in the brain stem fibre. He indicates the extensiveness of the reflex, a dimpling of the chin generated by stimulation of the palm, is greater than usually found because any stimulation along the entire arm generated it.

He described her condition as a persistent vegetative state.

In response to questions concerning her dependency on the respirator, he acknowledged that the information of Dr. Javed showing respiratory difficulty and low oxygen in the blood while off the respirator establishes her need to continue on it if her life is to continue.

He described the responses to caloric stimulation as abnormal.

He is the only expert who testified on the concepts of "ordinary" and "extraordinary" medical treatment. Essentially, he considers use of a respirator at the admission of a patient an "ordinary" medical practice. He equates the usage of it with an "extraordinary" practice when it is used for a prolonged period of time in concert with other hospital resources including extensive nursing care. He acknowledges the term "extraordinary" lacks precision in definition.

Testimony of other doctors reflects an inclination

that the use of the respirator is an ordinary medical practice.

The decision to request removal of their daughter from the respirator, understandably, came tortuously, arduously to the Quinlans. At the outset, they authorized Dr. Morse to do everything he could to keep her alive, believing she would recover. They participated in a constant vigil over her with other family members. They were in constant contact with the doctors, particularly Dr. Morse, receiving day by day reports concerning her prognosis which, as time passed, became more and more pessimistic and more and more discouraging to them.

Mrs. Quinlan and the children were the first to conclude Karen should be removed from the respirator. Mrs. Quinlan, working at the local parish church, had ongoing talks with Father Trapasso, who supported her conclusion and indicated that it was a permissible practice within the tenets of Roman Catholic teachings.

Mr. Quinlan was slower in making his decision. His hope for recovery continued despite the disheartening medical reports. Neither his wife nor Father Trapasso made any attempt to influence him. A conflict existed between letting her natural body functioning control her life and the hope for recovery. Precisely when he came to a decision is not clear. By his testimony he indicated early September but he signed a release to the hospital dated July 31, 1975 hereafter referred to, which makes it reasonably inferrable the decision was made in July. Once having made the decision, he sought Father Trapasso's encouragement, which he received.

Father Trapasso based his support of the position taken by the Quinlans on the traditional,

moral precepts of the Roman Catholic faith and upon a declaration, designated an *allocutio*, by Pope Pius XII made on November 24, 1957. Speaking to a group of anesthesiologists the Pope was requested to respond to the question: "When the blood circulation and the life of a patient who is deeply unconscious because of a central paralysis are maintained only through artificial respiration, and no improvement is noted after a few days, at what time does the Catholic Church consider the patient 'dead', or when must he be declared dead according to natural law?" The Papal response was "Where the verification of the fact in particular cases is concerned, the answer cannot be deduced from any religious and moral principle and, under this aspect, does not fall within the competence of the Church. Until an answer can be given, the question must remain open. But considerations of a general nature allow us to believe that human life continues for as long as its vital functions - distinguished from the simple life of organs - manifest themselves spontaneously or even with the help of artificial processes. A great number of these cases are the object of insoluble doubt, and must be dealt with according to the presumptions of law and of fact of which we have spoken."

Father Trapasso acknowledges it is not a sinful act under the church teachings or the Papal *allocutio* to either continue extraordinary treatment or discontinue it. It is acknowledged to be a matter left optional to a Roman Catholic believer. Mr. Quinlan indicates had Roman Catholic traditions and morals considered it a sin, he would not be seeking termination of the respiratorial support. Mr. Quinlan avers Karen's natural bodily functions should be allowed to operate free of the respirator. He states

then if it is God's will to take her she can go on to life after death and that is a belief of Roman Catholics. He asserts he does not believe or support the concept of euthanasia.

Once having made the determination, the Quinlans approached hospital officials to effectuate their decision. Father Paschal Caccavalle, Chaplain of St. Clare's, at a meeting between hospital representatives and the Quinlans, read the Papal *allocutio* of November 1957.

The Quinlans on July 31, 1975, signed the following:

> "We authorize and direct Doctor Morse to discontinue all extraordinary measures, including the use of a respirator for our daughter Karen Quinlan.
>
> "We acknowledge that the above named physician has thoroughly discussed the above with us and that the consequences have been fully explained to us. Therefore, we hereby RELEASE from any and all liability the above named physician, associates and assistants of his choice, Saint Clare's Hospital and its agents and employees."

The Quinlans, upon signing the release, considered the matter decided. Dr.Morse, however, felt he could not and would not agree to the cessation of the respirator assistance. He testified, - characterizing the issue of extraordinary treatment and the termination of it as something brought up suddenly in July - he advised the Quinlans prior to the time of the release, that he wanted to check into the matter further before giving his approval. After checking on other medical case histories, he

concluded to terminate the respirator would be a substantial deviation from medical tradition, that it involved ascertaining "quality of life", and that he would not do so.

Karen Quinlan is quoted as saying she never wanted to be kept alive by extraordinary means. The statements attributed to her by her mother, sister and a friend are indicated to have been made essentially in relation to instances where close friends or relatives were terminally ill. In one instance, an aunt, in great pain, was terminally ill from cancer. In another instance,the father of a girl friend was dying under like circumstances. In a third circumstance, a close family friend was dying of a brain tumor. Mrs. Quinlan testified her daughter was very full of life, that she loved life and did not want to be kept alive in any way she would not enjoy life to the fullest.

No testimony was elicited concerning the nature and extent of the assets of Karen Quinlan. By affidavit in support of the application, Joseph Quinlan indicates she receives $157.70 per month from a Federal Supplemental Security Income program and has a personal estate valued at approximately $300 consisting primarily of personal possessions. This information is deemed adequate to satisfy proof requirements under Rule 4:83.

Plaintiff urges the Court may resolve the matter in his favor through Declaratory Judgment and its inherent equitable powers. He urges there is a sufficient controversy to justify declaratory relief. He asserts an injunction should issue to prevent the risk of arrest and prosecution that might result from the Court's authorization. He contends under the equitable doctrine of substituted judgment this Court

can act in Karen Quinlan's best interest by authorizing the cessation of the respirator. He asserts Karen Quinlan and her family have by virtue of the constitutional right of privacy a right of self-determination which extends to the decision to terminate "futile use of extraordinary medical measures". Also asserted are the constitutional right of free exercise of religious belief and freedom from cruel and unusual punishment as grounds for granting the sought relief.

All defendants rely on *John F. Kennedy Memorial Hospital v. Heston*, 58 *N.J.* 576 (1971) to challenge the constitutional claims asserting no constitutional right to die exists and arguing a compelling State interest in favor of preserving human life.

They all, essentially, contend, since Karen Quinlan is medically and legally alive, the Court should not authorize termination of the respirator, that to do so would be homicide and an act of euthanasia.

The doctors suggest the decision is one more appropriately made by doctors than by a court of law and that under the circumstances of this case a decision in favor of the plaintiff would require ascertainment of quality of life standards to serve as future guide lines.

The Prosecutor, if plaintiff is granted the relief sought, requests a declaratory judgment "with regard to the effect of the homicide statutes and his duty of enforcement." *Brief* for Defendant Prosecutor at 3.

The hospital also seeks a declaratory judgment that the criteria outlined by the Ad Hoc Committee of the Harvard Medical School to Examine the

Definition of Brain Death be sanctioned as the ordinary medical standards for determination of brain death.

No party contests the jurisdiction of the Court to consider the application.

The case presented is:

Given the facts that Karen Quinlan is now an incompetent in a persistent vegetive state, that at the outset of her unconsciousness her parents placed her under the care and treatment of Dr. Morse, and through him Dr. Javed and St.Clare's Hospital, urging everything be done to keep her alive, that the doctors and hospital introduced life sustaining techniques, does this Court have the power and right, under the mantle of either its equity jurisdiction, the constitutional rights of free exercise of religion, right of privacy or privilege against cruel and unusual punishment, to authorize the withdrawing of the life sustaining techniques?

I.

I pause to note the scope of my role. I am concerned only with the facts of this case and the issues presented by them. It is not my function to render an advisory opinion.[3] In this age of advanced medical science the prolongation of life and organ transplants, it is not my intent nor can it be, to resolve the extensive civil and criminal legal dilemmas engendered.[4]

[3] *Crescent Pk. Tenants Assoc. v. Realty Eq. Corp. of N.Y.*, 58 *N.J.* 98,, 107 (1971); *In re Judges in Chancery*, 101 *N.J. Eq.* 9 (Ch. 1927)

[4] *See Tucker v. Lower*, No. 2831 (Ct. of L. & Eq. Richmond, Va., May 23, 1972); *People v. Lyons*, 15 Crim. L. Rptr. 2240 (Cal. Super. Ct., May 21, 1974; *State v. Brown*, 8 *Ore. App.* 72, 491 *P. 2d.* 1193 (Ct. App. 1971); *In re New York City Health and Hospitals Corporation v. Sulsona*, 81 *N.Y.* Misc. 2d. 1002, 367 N.Y.S. 2d. 686 (Sup. Ct. 1975); *Symposium Issue - Euthanasia*, 27 *Baylor L. Rev.* 10 (1975); Berman "The Legal Problems of

The absence of specific legal precedence does not delimit the scope of my determination. The principles of prior decisions are to be considered, although, as Cardozo points out, little faith should be placed on dicta. Cardozo, "The Nature of the Judicial Process" 29 (1921).[5]

II.

The matter is presented to the Court, aside from constitutional considerations, in the principle framework of inherent equitable concepts and, corollary thereto, declaratory relief.[6]

Plaintiff invokes the inherent power of an Equity Court as the protector and general guardian of all persons under a disability. He urges under the doctrine of *parens patriae*, the Court as representative of the sovereign, may intervene "in the best interests" of Karen Quinlan and allow her to die a natural death. The doctrine has been utilized in

Organ Transplantation, 13 *Vill. L. Rev.* 751 (1968); Note "The Time of Death -A Legal Ethical and Medical Dilemma," 18 *Cath. Law.* 242 (1972).

[5] It is suggested to make "the life or death" decision here involves apotheosis and should therefore be avoided entirely. It is the nature of the judicial process, once set in motion, to deal with an issue no matter how grave its consequences. To carry out the judicial process, I most humbly suggest is NOT an effort to exercise Divine Powers.

The onus of the judicial process for me, in this instance, is unparalled.

[6] This Court sits as the General Equity part of the Chancery Division of the Superior Court. The New Jersey Constitution, vesting original general jurisdiction in the Superior Court divides it into the Appellate, Law and Chancery Divisions. *N.J.Constitution*, Art. VI, §111, Para. 2 & 3. The Law and Chancery Divisions, subject to rules of the Supreme Court, each possess the power and functions of the other to dispense legal and equitable relief. *N.J. Const.*, Art. VI, §111, Para. 4. The Supreme Court Rules provide if the principal relief sought is equitable in nature an act is to be commenced in the Chancery Division. *Rule* 4:3-1 (a) (1). *See Steiner v. Stein*, 2 *N.J.* 367 (1949) and *Fleischer v. James Drug Stores*, 1 *N.J.* 138 (1948) for the significance and manner of cases instituted in Chancery involving equitable and legal issues. Further, the exercise of jurisdiction by a Court of Equity is discretionary and may extend to declaratory relief,

this State in the management and administration of an incompetent's estate, *In re Trott*, 118 *N.J. Super.* 436, 440 (Ch Div. 1972), but not in his personal affairs. The doctrine has been extended to the personal affairs of incompetents and others suffering under disability in other jurisdictions. *Strunk v. Strunk*, 445 *S.W.* 2d. 145, 147-148 (Ky. Ct. App. 1969), *Hart v. Brown*, 29 *Conn. Sup.* 368, 289 *A.* 2d 386 (1972)

> As part of the inherent power of equity, a Court of Equity has full and complete jurisdiction over the persons of those who labor under any legal disabiity... The Court's action in such a case is not limited by any narrow bounds, but it is empowered to stretch forth its arm in whatever direction its aid and protection may be needed. While this is indeed a special exercise of equity jurisdiction, it is beyond question that by virtue thereof the Court may pass upon purely personal rights. 27 *Am. Jur.* 2d. Equity §69 (1966).

The power to act for an incompetent in the affairs of his estate and person has been denominated "the doctrine of substituted judgment". *Strunk v. Strunk, supra.* at 148; *Hart v. Brown, supra.* at 387.

The *Strunk* case involved a request to the Court by the committee for a 27-year old incompetent male to permit the transplant-of the incompetent's kidney to his fatally ill brother. The Court authorized the transplant finding the risks to the incompetent limited and determining the continued existence of the brother essential to the well being of the

although it is not within the inherent equitable jurisdiction. *Unterman v. Unterman*, 19 *N.J.* 507, 515 (1955): *But see Government Employees Ins. Co. v. Butler*, 128 *N.J. Super.* 492 (Ch. Div. 1974).

incompetent.

In the *Hart* case the Court considered the transplant of a kidney from one identical 7-year old twin to the other. Noting the absence of risk to the donor, the strong, close, relationship between the infants and the need of the donee twin for the kidney if her life was to continue, the Court granted the parents the authority to consent to the operations involved.

Both *Hart* and *Strunk* are persuasive in favor of the existence of the authority of this Court to aid and protect Karen Quinlan and act in her best interests.

The nature and extent to which that authority is to be exercised requires analysis.

It has been stated that the power of equity is "the power possessed by judges - and even the duty resting upon them - to decide every case according to the high standard of morality and abstract right; that is the power and duty of a judge to do justice ..." 1 *Pomeroy Jurisprudence* §44 at 57 (1941).

It involves the obedience to dictates of morality and conscience. *Id.* §45 at 59. It may not disregard statutory law and it looks to the intent rather than the form.

These dictates set the framework for the authority this Court may exercise on Karen's behalf.

Equity speaks of conscience. That conscience is not the personal conscience of the judge. For, if it were, the compassion, empathy, sympathy I feel for Mr. and Mrs. Quinlan and their other two children would play a very significant part in the decision. It is a judicial conscience, "a metaphorical term, designating the common standard of civil right and expediency combined, based upon general principles, and limited by established doctrines to

which the court appeals, and by which it tests the conduct and right of the suitors". 1 *Pomeroy Equity Jurisprudence*, §57 at 74. The rationale behind not allowing the personal conscience and therefore the noted emotional aspects are that while it may result in a decision based on a notion of what is right for these individuals, the precedential effect on future litigation, particularly in light of the raging issue of euthanasia, would be legally detrimental.[7]

Equity also speaks of morality. The morality involved is that of society. The standards evolved through social advancement in a stablized community life.

Karen Quinlan is by legal and medical definition alive. She is not dead by the Ad Hoc Committee of Harvard Medical School standards nor by the traditional definition, the stoppage of blood circulation and related vital functions.[8] The quality of her living is described as a persistent vegetative state, a description that engenders total sorrow and despair in an emotional sense. She does not exhibit cognitive behavior (i.e., the process of knowing or perceiving). Those qualities unique to man, the

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[7] This does not preclude the setting of a precedent, it merely requires the setting to be within the concept of judicial conscience.

[8] The advent of life supportive techniques and advanced medical knowledge have raised a controversy over an adequate legal definition of death.

Black's Law Dictionary (4th ed. rev. 1968) defines death as:

> The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc. [at 488].

The difficulty with a definition which involves blood circulation develops in clinical situations, as present here, where the patient's

higher mental functions, are absent. Her condition is categorized as irreversible and the chance of returning to discriminate functioning remote. Nevertheless, while her condition is neurologically activated, due to the absence of a pre-hospital history, and in light of medical histories showing other comatose patients surviving longer coma periods, there is some medical qualification on the issue of her returning to discriminative functioning and on whether she should be removed from the respirator. There is a serious question whether she can live off the respirator and survive (at least two physicians indicated she could not). It is also apparent that extensive efforts to wean her from the respirator created a danger of more extensive brain injury. There is no treatment suggested.

The judicial conscience and morality involved in considering whether the Court should authorize Karen Quinlan's removal from the respirator are

cardio-respiratory system is mechanically supported, causing the blood to circulate and the related vital functions to continue. There obviously can be no death under *Black's* traditional definition as long as the heart and lungs remain intact. Yet, all other signs of life as reflected in the Ad Hoc Committee of Harvard Medical School can cease.

In clinical situations, such as the case at bar, the need for adoption of brain death as a legal definition is urged by many authorities. The establishment of an appropriate modern day legal definition of death and the criteria to be followed are the subject of a plethora of written material, some of which are: Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, Report: A definition of "Irreversible Coma", 208 J.A.M.A. 85 (1968); A Statement of the Cerebral Survival Program by The Project Directors, Cerebral Survival Program (performed under contracts with NINDS. Collaborative and Field Research) National Institute of Health, Bethesda, Md.; Task Force on Death and Dying of the Institute of Society, Ethics, and the Life Sciences, Report: "Refinements in the Criteria for the Determination of Death": An Appraisal, 221 J.A.M.A.48 (1972); Capron and Kass, "A Statutory Definition of the Standard for Determining Human Death: An Appraisal and a Proposal", 121 *U. Pa. L. Rev.* 87 (1972); Friloux, Death, When Does It Occur?" 27 *Baylor L. Rev.* 10 (1975); Halley & Harvey, "Medical vs. Legal Definitions of Death", 204 J.A.M.A. 103 (1968); Hirsh, "Brain Death", 21 *Med. Tr. Tech. Q.* 377 (1975).

inextricably involved with the nature of medical science and the role of the physician in our society and his duty to his patient.

When a doctor takes a case, there is imposed upon him the duty "to exercise in the treatment of his patient the degree of care, knowledge and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in his field". *Schueler v. Strelinger*, 43 *N.J.* 330, 344 (1964). If he is a specialist he "must employ not merely the skill of a general practitioner, but also that special degree of skill normally possessed by the average physician who devotes special study and attention to the particular organ or disease or injury involved, having regard to the present state of scientific knowledge". *Clark v. Wichman*, 72 *N.J. Super.* 486, 493 (App. Div. 1962). This is the duty that establishes his legal obligations to his patients.

There is a higher standard, a higher duty, that encompasses the uniqueness of human life, the integrity of the medical profession and the attitude of society toward the physician and therefore the morals of society. A patient is placed, or places himself, in the care of a physician with the expectation that he (the physician) will do everything in his power, everything that is known to modern medicine, to protect the patient's life. He will do all within his human power to favor life against death.[9]

The attitudes of society have over the years developed a significant respect for the medical profession. Society has come to request and expect this higher duty.

[9] *See Epstein, The Role of the Physician in Prolongation of Life, Controversies in Medicine II,* Saunders & Co. (1973).

But the doctor is dealing in a science which lacks exactitude, *Schueler v. Strelinger, supra.* at 344, a science that has seen significant changes in recent years, a science that will undoubtedly have prodigious advancements in the future but a science which still does not know the cause of some afflictions and which does not know all the interrelationships of the body functions. In recent years, open heart surgery and organ transplantation have made continuation of life possible where the patient is suffering from a fatal disability. The cause of cancer remains to a major extent unknown, but advances have been made in cures and remissions. The brain, the only organ incapable of transplant to date, as Dr. Morse points out, is still, even among neuroanatomists, unknown insofar as the interrelationships of some of its parts and how these parts are controlled.

Doctors, therefore, to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultations with other physicians, must guide their decision making processes in providing care to their patient. The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts? Aside from the constitutional arguments, plaintiff suggests because medical science holds no hope for her recovery, because if Karen was conscious she would elect to turn off the respirator and finally because there is no duty to keep her alive.

None of the doctors testified there was no hope. The hope for recovery is remote but no doctor talks in the absolute. Certainly he cannot and be credible in light of the advancements medical science has known and the inexactitudes of medical science.

There is a duty to continue the life assisting apparatus, if within the treating physician's opinion, it should be done. Here Dr. Morse has refused to concur in the removal of Karen from the respirator. It is his considered position that medical tradition does not justify that act. There is no mention in the doctor's refusal of concern over criminal liability and the Court concludes that such is not the basis for his determination. It is significant that Dr. Morse, a man who demonstrated strong empathy and compassion, a man who has directed care that impressed all the experts, is unwilling to direct Karen's removal from the respirator.

The assertion that Karen would elect, if competent to terminate the respirator requires careful examination.

She made these statements at the age of twenty. In the words of her mother, she was full of life. She made them under circumstances where another person was suffering, suffering in at least one instance from severe pain. While perhaps it is not too significant, there is no evidence she is now in pain. Dr. Morse describes her reacting to noxious stimuli - pain - a reflex but not indicative that she is sensing the pain as a functioning human being does. The reaction is described as stereotyped and her reflexes show no adjustment that would indicate she mentally experiences pain.

The conversations with her mother and friends were theoretical ones. She was not personally

involved. It was not under the solemn and sobering fact that death is a distinct choice, *see In re Estate of Brooks*, 32 *Ill.* 2d. 361,205 *N.E.*2d. 435(1965). Karen Quinlan while she was in complete control of her mental faculties to reason out the staggering magnitude of the decision not to be "kept alive" did not make a decision. This is not the situation of a Living Will which is based upon a concept of informed consent.[10]

While the repetition of the conversations indicates an awareness of the problems of terminal illness, the elements involved - the vigor of youth that espouses the theoretical good and righteousness, the absence of being presented the question as it applied to her - are not persuasive to establish a probative weight sufficient to persuade this Court that Karen Quinlan would elect her own removal from the respirator.

The breadth of the power to act and protect Karen's interests is, I conclude, controlled by a judicial conscience and morality that dictate the determination whether or not Karen Ann Quinlan be removed from the respirator is to be left to the treating physician. It is a medical decision, not a judicial one. I am satisfied that it may be concurred in by the parents but not governed by them. This is so because there is always the dilemma of whether it is the conscious beings relief or the unconscious beings welfare that governs the parental motivation.

It is also noted the concept of the Court's power over a person suffering under a disability is to protect and aid the best interests. As pointed out, the *Hart* and *Strunk* cases deal with protection as it relates to

[10] Kutner, *The Living Will - Coping With The Historical Event of Death*, 27 *Baylor, L. Rev.* 1, 39 (1975)

the future life of the infants or incompetent. Here the authorization sought, if granted, would result in Karen's death. The natural processes of her body are not shown to be sufficiently strong to sustain her by themselves. The authorization, therefore, would be to permit Karen Quinlan to die. This is not protection. It is not something in her best interests, in a temporal sense, and it is in a temporal sense that I must operate whether I believe in life after death or not. The single most important temporal quality Karen Ann Quinlan has is life. This Court will not authorize that life to be taken from her.

As previously indicated, equity follows the law. When positive statutory law exists, an Equity Court cannot supersede or abrogate it. The Common Law concept of homicide, the unlawful killing of one person by another, is reflected in our codified law. *N.J.S.A.* 2A:113-1, 2 and 5. The intentional taking of another's life, regardless of motive, is sufficient grounds for conviction. *State v. Ehlers*, 98 *N.J.L.* 236, 240-241 (E. & A. 1922); *See People v. Conley*, 64 *Cal.* 2d. 310, 411 *P.* 2*d.* 9ll, 49 *Cal. Rptr.* 8l5 (Sup. Ct. 1966). Humanitarian motives cannot justify the taking of a human life. *See State v. Ehlers, supra*, at 240-241. The fact that the victim is on the threshold of death or in terminal condition is no defense to a homicide charge. *State v. Mally*, 139 *Mont.* 599, 366 *P.* 2d. 868, 873 (Sup. Ct. 1961).

New Jersey has adopted the principles of the Common Law against homicide. While some of the aforecited decisions are from other jurisdictions, they are reflections of the Common Law and therefore dispositive of the manner this State would treat like circumstances. It is a reasonable construction that the law of this State would preclude the removal of

Karen Quinlan from the respirator. As such, a Court of Equity must follow the positive statutory law; it cannot supersede it.[11]

A significant amount of the legal presentation to the court has involved whether the act of removing Karen from the respirator constitutues an affirmative act, or could be considered an act of omission.[12] An intricate discussion on semantics and form is not required since the substance of the sought for authorization would result in the taking of the life of Karen Quinlan when the law of the State indicates that such an authorization would be a homicide.

III.

The proceeding brings consideration attention and focus on the physical condition of Karen Quinlan. The results thereof are that in the future the decisions and determinations of the treating doctors and the hospital will be the subject of abnormal scrutiny.

The hospital, through amendment to the pretrial order, seeks a determination "whether the use of the criteria developed and enunciated by the Ad Hoc Committee of Harvard Medical School on or about August 5, 1968, as well as similar criteria, by a physician to assist him in determination of the death of a patient whose cardiopulmonary functions are

11 Certainly the question must be asked, did the Common Law contemplate the continued existence of a human being, where that human being, although medically and legally alive, has been given all the diagnostic and therapeutic treatment available and should not the natural functions of that human being be permitted to progress in a normal way without the law against homicide being a deterrent?

12 For a complex and reasoning discussion on these issues, *see* Fletcher "Prolonging Life", 42 *Wash. L. Rev.* 999 (1967).

being artificially sustained, is in accordance with ordinary and standard medical practice".

The scope of that request is extremely broad. It deals not with the question of Karen Quinlan but a theoretical patient. To the extent that it goes beyond this case, it is a request to make a determination in the abstract and not a proper subject for judicial determination. *Crescent Park Tenants Assoc. v. Realty Eq. Corp. of N. Y., supra* at 107.

Counsel for the hospital, to avoid the objection that the request deals in an abstraction and therefore constitutes a proscribed advisory opinion, by letter subsequent to trial, suggests a refinement of the stated issue to refer specifically to Karen Quinlan.

The jurisdiction of the Court to deal with such an issue must exist, if at all, under the authority of the Declaratory Judgment Act. Designed to provide judicial declaration of the rights and obligations of parties, the Act is a device whereby uncertainty with respect to rights and legal relations may be alleviated. *N.J S.A.* 2A:16-50 et seq.; *Union Co. Bd. of Freeholders v. Union Co. Park Comm.*, 41 *N.J.* 333, 336-337 (1964); *Bergen County v. Port of N.Y. Authority*, 32 *N.J.* 303, 307 (1960); *N. J. Home Builders Assn. v. Div. on Civil Rights*, 81 *N. J. Super.* 243, 251 (CH. Div. 1963).

The controversy, however, must have matured and not be something sought in advance of its occurrence. *Rego Industries Inc. v. American Mod. Metals Corp.*, 91 *N. J. Super.* 447, 453 (App. Div. 1966).

The application is prospective and in advance of the controversy. The doctors do not seek the determination - in fact, they oppose it.

Additionally, just as the matter of the nature and

extent of care and treatment of a patient and therefore the patient's removal from a respirator is a medical decision based upon ordinary practice, so, too, is the decision whether a patient is dead and by what medical criteria Whether Karen Quinlan one day becomes brain dead and therefore should be removed from the respirator is a decision that will have to be based upon the extant ordinary medical criteria at the time.

IV.

A. Right of Privacy - Right of Self Determination

The "Right of Privacy", identified as such, was first recognized in *Griswold v. Connecticut*, 381 *U S.* 479, 19 *L. Ed. 2d* 510 (1965). The source of this right has various explanations. *Roe v. Wade*, 410 *U.S.* 113, 35 *L. Ed. 2d* 147 (1972).

Justice Blackman, writing for the Court in *Wade*, indicated:

> The Constitution does not explicitly mention any right of privacy. ...[T]he Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy does exist under the Constitution. In varying contexts the Court or individual Justices have, indeed, found at least the roots of that right in the First Amendment ...; in the Fourth and Fifth Amendments, ...; in the penumbras of the Bill of Rights, ... in the Ninth Amendment, ...; or in the concept of liberty guaranteed by the first section of the Fourteenth Amendment, ... These decisions make it clear that only personal rights that can be deemed "fundamental" or "implicit in the concept of

> ordered liberty, ... , are included in this guarantee of personal privacy. [410 *U.S.* at 152, 35 *L. Ed. 2d* at 176; citations omitted].

Plaintiff suggests, citing *Griswold* in concert with *Union Pacific Railway Company v. Butsford*, 141 *U.S.* 250 35 *L. Ed.* 734 (1891) that the right of self determination and right of privacy are synonomous. [13] He also suggests the right is exercisable by a parent for his child.

It is not significant to this opinion whether or not the right of self-determination is within the scope of the right of privacy. What is significant is the extent to which it is subject to a compelling State interest, *Roe v. Wade, supra*, and whether the right can be exercised by the parent for his child.

The majority of cases dealing with the refusal of an individual to accept treatment which created an exposure to death involved mature, competent adults. *U. S. v. George*, 239 *F. Supp.* 752 (D. Conn. 1965); *In re Osborne*, 294A.2*d*. 372 (D.C. Ct.App. 1972); *In re Brooks Estate, supra; In re Yetter*, 62 *Pa.* D. & C. 2d. 619 (C.P., Northampton County Ct. 1973); *John F. Kennedy Memorial Hospital v. Heston, supra*, (the competency of the adult to make the decision at the specifc instance was questionable because of her condition of shock). None, however, dealt with an incompetent adult, as here, totally unaware of the problem.

The disability places the Court in a *parens patriae* circumstance, significantly different from the instance of a competent adult's effort to control his

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[13] *See Sharp v. Crofts* "Death with Dignity The Physician's Civil Liability", 27 *Baylor L. Rev.* 88, 89 (1975); *Contra*, Byrn "Compulsory Lifesaving Treatment for the Competent Adult", 44 *Fordham L. Rev.* 1 (1975).

body. This is true in spite of the prior statements of Karen Quinlan concerning dispensing with extraordinary case. For, as indicated, the proofs do not meet a standard clear enough to have the probative weight sufficient to convince the Court that Karen Quinlan, in full command of the facts, would favor death.

The judicial power to act in the incompetent's best interest in this instance selects continued life and to do so is not violative of a constitutional right.

The majority of the right of privacy cases, *Roe v. Wade*, supra, (abortion); *Eisenstadt v Baird*, 405 *U.S.* 438, 31 *L. Ed. 2d.* 349 (1972). (contraception), *Griswold v. Connecticut, supra* (contraception); *Stanley v. Georgia*, 394 *U.S.* 557, 22 *L. Ed. 2d.* 542 (1969) (possession of obscene films for own personal viewing) involved a claim which asserted a life practice for the individual involved. The compelling state interest found lacking in *Wade, Baird, Griswold* and *Stanley* is appropriate here in the state's interest in preservation of life and the extension of the Court's protection to an incompetent. *John F. Kennedy Memorial Hospital v. Heston, supra.*

The power of the parents to exercise the constitutional right is found lacking on several grounds: First, the only cases where a parent has standing to pursue a constitutional right on behalf of an infant are those involving continuing life styles. *Wisconsin v. Yoder, supra; Pierce v. Society of Sisters*, 268 *U.S.* 510, 69 *L. Ed.* 1070 (1925); *Meyer v Nebraska*, 262 *U.S* 390, 67 *L. Ed.* 1042 (1923). Second, the parents urged Dr. Morse to do everything at the outset to save Karen's life. The parents now ask him to abandon his conscience and

allow her life to end. In *Roe v Wade*, the court refused to hold that the right of privacy included the unlimited right to body control. In a like manner, the right to privacy, being urged through a parent, must be fettered, when in conflict with a doctor's duty to provide life giving care.[14]

There is no constitutional right to die that can be asserted by a parent for his incompetent adult child.

B. Free Exercise

Religious beliefs are absolute under the Free Exercise Clause but practice in pursuit thereof is not free from governmental regulation. *Reynolds v. United States*, 98 *U.S.* 145, 25 *L. Ed.* 244 (1878); *Prince v. Massachusetts*, 321 *U.S.* 158, 88 *L. Ed.* 645 (1944); *Sherbert v. Verner*, 374 *U.S.* 398, 10 *L. Ed. 2d.* 965 (1963). The imposition of the regulation can be based on "only those interests of the highest order". *Wisconsin v. Yoder*, 406 *U.S.* 205, 32 *L. Ed. 2d.* 15 (1972). "To have the protection . . . the claims must be rooted on religious belief". *Id.* at 215, 32 *L. Ed. 2d.* at 25

The religious belief here asserted is twofold:

(1) that the discontinuance of extraordinary care to Karen Quinlan is not a mortal sin; and (2) to interfere with her natural body functions prevents her from reaching a better life in the hereafter.

The absence of mortal sin contention is based, according to Father Trapasso, on the Papal *allocutio* of November 24, 1957 and Roman Catholic traditions and morals. The impetus of the thought is that it is neither a mortal sin to continue nor discontinue "extraordinary" means of support for the body functions. The Court does not consider the

[14] These arguments are equally valid under the Free Exercise claim.

"extraordinary" versus "ordinary" discussions viable legal distinctions. The essence of the contention is that it is optional with the Roman Catholic involved and to do either does not conflict with the teachings of the Church. It is not a dogma of the Church. It is not a claim "rooted in religious belief". There is no governmental or other interference with religious belief here that is caused by the Court's refusal to authorize the termination of the respirator.

The temporal world is what the Free Exercise clause deals with -- not the hereafter. All instances where a religious belief has been freed of attempted governmental interference dealt with life styles and life circumstances.

In *John F. Kennedy Memorial Hospital v. Heston*, 58 *N.J.* 576 (1971), Justice Weintraub indicated "it seems correct to say there is no constitutional right to die". (at 580) In doing so, the Court recognized the State's interest in preserving life. Equally, this Court recognizes the State's interest in preserving life, particularly in this instance where the Court sits in the capacity of *parens patriae*. There is a presumption that one chooses to go on living. The presumption is not overcome by the prior statements of Karen Quinlan. As previously noted, she did not make the statements as a personal confrontation. Additionally, it is not Karen who asserts her religious belief but her parents. In those instances where the parental standing to assert the religious belief has been upheld it dealt with future life conduct of their children, not the ending of life. *Wisconsin v. Yoder*, 406 *U.S.* 205, 32 *L. Ed.* 15 (1972); *Pierce v. Society of Sisters*, 268 *U.S.* 510, 69 *L. Ed. 2d.* 1070 (1925).

The right to life and the preservation of it are "interests of the highest order" and this Court deems it constitutionally correct to deny Plaintiff's request.

C. Cruel and Unusual Punishment:

It is argued to deny the suspension of the "futile use of extraordinary measures after the dignity, beauty, promise and meaning of earthly life have vanished", is cruel and unusual punishment proscribed by the Eighth Amendment of the United States Constitution. Brief for Plaintiff at 29.

The nature and scope of the Cruel and Unusual Punishment concept is set forth in *Furman v. Georgia*, 408 *U.S.* 238, 33 *L. Ed. 2d.* 346, *reh. den.* 409 *U.S.* 902, 34 *L. Ed. 2d.* 164 (1972). All of the concurring and dissenting opinions in *Furman* make it clear the proscription is directed to state imposed criminal sanctions, not the situation presented here. Justice Douglas in his concurring opinion, in discussing the fact that the Eighth Amendment may have found its source in the English Bill of Rights of 1689 indicates the concern was "primarily with selection or irregular application of harsh penalties and that its aim was to forbid arbitrary and discriminatory penalties of a severe nature". *Id.* at 242, 33 *L. Ed. 2d.* at 351. The impetus for the concept was to preclude judicial or legislative imposition of punishment in the guise or nature of criminality.

Plaintiff cites the following language of Justice Brennan's concurring opinion in *Furman* for his contention:

> The primary principle is that a punishment must not be so severe as to be degrading to the

dignity of human beings. [at 271]

* * *

[T]he State must not arbitrarily inflict a severe punishment. This principle derives from the notion that the State does not respect human dignity when without reason, it inflicts upon some people a severe punishment that it does not inflict on others. [at 274]

* * *

A third principle inherent in the Clause is that a severe punishment must not be unacceptable to contemporary society. Rejection by society, of course, is a strong indication that a severe punishment does not comport with human dignity. [at 277]

* * *

The final principle inherent in the Clause is that a severe punishment must not be excessive. A punishment is excessive under the principle if it is unnecessary: The infliction of severe punishment by the State cannot comport with human dignity when it is nothing more than pointless infliction of suffering. [at 279]

A careful reading of these principles does not support plaintiff here. Continuation of medical treatment, in whatever form, where its goal is the sustenance of life is not something degrading, arbitrarily inflicted, unacceptable to contemporary society or unnecessary.

The Eighth Amendment has no applicability to this civil action.

V.

Joseph Quinlan applies to be appointed guardian ad litem of his daughter's person and property. Karen Quinlan is incompetent and unfit and unable to govern herself as to manage her affairs. *R.* 4:83-2. As next of kin, Mr.Quinlan qualifies to be her guardian, *N.J.S.A.* 3A:6-36, unless it is shown his appointment would be contrary to Karen's best interest. *In re Roll*, 117 *N.J. Super.* (App. Div. 1971). The guardian ad litem opposes his appointment.

The responsibility of the guardian over property is to manage the business affairs of the incompetent. There is no reason that Mr.Quinlan should not serve in this capacity.

The responsibility of the guardian over the person of the incompetent is to make the decisions, in this instance that relate to her welfare insofar as those decisions are within the person's control. I have ruled it is a medical decision whether or not Karen should be removed from the respirator. Just as that decision is a medical one, the continued care and treatment of Karen is a medical one. There will be, however, from time to time medical decisions relating to further treatment that will require a guardian's counsel, advice and concurrence. This is reflected by the testimony of Dr. Morse.

Mr. Quinlan impressed me as a very sincere, moral, ethical and religious person. He is very obviously anguished over his decision to terminate what he considers the extraordinary care of his daughter. That anguish would be continued and magnified by the inner conflicts he would have if he were required to concur in the day to day decisions on the future care and treatment of his daughter. These

conflicts would have to offset his decision making processes. I, therefore, find it more appropriate and in Karen's interests if another is appointed.

For the same reasons, I do not feel Mrs. Quinlan should be appointed.

Daniel Coburn, Esq., who has acted on Karen's behalf throughout this proceeding, is appointed the guardian of her person. Both guardians shall serve without bond in accordance with law and the Rules of Court after qualification.

Judgment should be submitted accordingly.

/S/ Robert Muir, Jr., J.S.C.

Robert Muir, Jr., J.S.C.

SUPREME COURT OF NEW JERSEY
A-116 September Term 1975

In the Matter of :
KAREN QUINLAN, :
An Alleged Incompetent. :

Argued January 26, 1976
Decided March 31, 1976

On certification to the Superior Court, Chancery Division, whose opinion is reported at 137 N.J. Super. 227 (1975).

Mr. Paul W. Armstrong and Mr. James M. Crowley, a member of the New York Bar, argued the cause for appellant Joseph T. Quinlan (Mr. Paul W. Armstrong, attorney).

Mr. Daniel M. Coburn argued the cause for respondent Guardian Ad Litem Thomas R. Curtin.

Mr. William F. Hyland, Attorney General of New Jersey, argued the cause for respondent State of New Jersey (Mr. Hyland, attorney; Mr. David S. Baime and Mr. John DeCicco, Deputy Attorneys General, of counsel; Mr. Baime, Mr. DeCicco, Miss Jane E. Deaterly, Mr. Daniel Louis Grossman and Mr. Robert E. Rochford, Deputy Attorneys General, on the brief).

Mr. Donald G. Collester, Jr., Morris County Prosecutor, argued the cause for respondent County of Morris.

Mr. Ralph Porzio argued the cause for respondents Arshad Javed and Robert J. Morse (Messrs. Porzio, Bromberg and Newman, attorneys; Mr. Porzio, of counsel; Mr. Porzio and Mr. E. Neal Zimmerman, on the brief).

Mr. Theodore E. Einhorn argued the cause for respondent Saint Claire's Hospital.

Mr. Edward J. Leadem filed a brief on behalf of amicus curiae New Jersey Catholic Conference.

The opinion of the Court was delivered by

HUGHES, C.J.

THE LITIGATION

The central figure in this tragic case is Karen Ann Quinlan, a New Jersey resident. At the age of 22, she lies in a debilitated and allegedly moribund state at Saint Clare's Hospital in Denville, New Jersey. The litigation has to do, in final analysis, with her life,--its continuance or cessation,--and the responsibilities, rights and duties, with regard to any fateful decision concerning it, of her family, her guardian, her doctors, the hospital, the State through its law enforcement authorities, and finally the courts of justice.

The issues are before this Court following its direct certification of the action under the rule, R.2:12-1, prior to hearing in the Superior Court, Appellate Division, to which the appellant (hereafter "plaintiff") Joseph Quinlan, Karen's father, had appealed the adverse judgment of the Chancery Division.

Due to extensive physical damage fully described in the able opinion of the trial judge, Judge Muir, supporting that judgment, Karen allegedly was incompetent. Joseph Quinlan sought the adjudication of that incompetency. He wished to be appointed guardian of the person and property of his daughter. It was proposed by him that such letters of guardianship, if granted, should contain an express power to him as guardian to authorize the discontinuance of all extraordinary medical procedures now allegedly sustaining Karen's vital processes and hence her life, since these measures, he asserted, present no hope of her eventual recovery. A guardian ad litem was appointed by Judge Muir to represent the interest of the alleged

incompetent.

By a supplemental complaint,in view of the extraordinary nature of the relief sought by plaintiff and the involvement therein of their several rights and responsibilities, other parties were added. These included the treating physicians and the hospital, the relief sought being that they be restrained from interfering with the carrying out of any such extraordinary authorization in the event it were to be granted by the court. Joined, as well, was the Prosecutor of Morris County (he being charged with responsibility for enforcement of the criminal law), to enjoin him from interfering with, or projecting a criminal prosecution which otherwise might ensue in the event of, cessation of life in Karen resulting from the exercise of such extraordinary authorization were it to be granted to the guardian.

The Attorney General of New Jersey intervened as of right pursuant to R.4:33-1 on behalf of the State of New Jersey, such intervention being recognized by the court in the pretrial conference order (R.4:25-1 et seq.) of September 22, 1975. Its basis, of course, was the interest of the State in the preservation of life, which has an undoubted consitutional foundation.[1]

The matter is of transcendent importance,

[1] The importance of the preservation of life is memorialized in various organic documents. The Declaration of Independence states as self-evident truths "that all men *** are endowed by their Creator with certain unalienable Rights, that among these are Life, liberty and the pursuit of happiness." This ideal is inherent in the Constitution of the United States. It is explicitly recognized in our Constitution of 1947 which provides for "certain natural and unalienable rights, among which are those of enjoying and defending life ***." *N.J. Const.* (1947), Art. I, par. 1. Our State government is established to protect such rights, *N.J. Const.* (1947), Art. I, par. 2, and, acting through the Attorney General (*N.J.S.A.* 52:17A-4 (h)), it enforces them.

involving questions related to the definition and existence of death, the prolongation of life through artificial means developed by medical technology undreamed of in past generations of the practice of the healing arts;[2] the impact of such durationally indeterminate and artificial life prolongation on the rights of the incompetent, her family and society in general; the bearing of constitutional right and the scope of judicial responsibility, as to the appropriate response of an equity court of justice to the extraordinary prayer for relief of the plaintiff. Involved as well is the right of the plaintiff, Joseph Quinlan, to guardianship of the person of his daughter.

Among his "factual and legal contentions" under such Pretrial Order was the following:

1. Legal and Medical Death

(a) Under the existing legal and medical

[2] Dr. Julius Korein, a neurologist, testified:

A. *** [Y]ou've got a set of possible lesions that prior to the era of advanced technology and advances in medicine were no problem inasmuch as the patient would expire. They could do nothing for themselves an even external care was limited. It was--I don't know how many years ag they couldn't keep a person alive with intravenous feedings because they couldn't give enough calories. Now they have these high caloric tube feedings that can keep people in excellent nutrition for years so what's happened is these things have occurred all along but the technology has now reached a point where you can in fact start to replace anything outside of the brain to maintain something that is irreversibly damaged.

Q. Doctor, can the art of medicine repair the cerebral damage that was sustained by Karen?

A. In my opinion, no. ***

Q. Doctor, in your opinion is there any course of treatment that will lead to the improvement of Karen's condition?

A. No.

definitions of death recognized by the State of New Jersey, Karen Ann Quinlan is dead.

This contention, made in the context of Karen's profound and allegedly irreversible coma and physical debility, was discarded during trial by the following stipulated amendment to the Pretrial Order:

> Under any legal standard recognized by the State of New Jersey and also under standard medical practice, Karen Ann Quinlan is presently alive.

Other amendments to the Pretrial Order made at the time of trial expanded the issues before the court. The Prosecutor of Morris County sought a declaratory judgment as to the effect any affirmation by the court of a right in a guardian to terminate life-sustaining procedures would have with regard to enforcement of the criminal laws of New Jersey with reference to homicide. Saint Clare's Hospital, in face of trial testimony on the subject of "brain death", sought declaratory judgment as to:

> Whether the use of the criteria developed and enunciated by the Ad Hoc Committee of Harvard Medical School on or about August 5, 1968, as well as similar criteria, by a physician to assist in determination of the death of a patient whose cardiopulmonary functions are being artifically sustained, is in accordance with ordinary and standard medical practice.[3]

It was further stipulated during trial that Karen was indeed incompetent and guardianship was

[3]The Harvard Ad Hoc standards, with reference to "brain death," will be discussed *infra*.

necessary, although there exists a dispute as to the determination later reached by the court that such guardianship should be bifurcated, and that Mr. Quinlan should be appointed as guardian of the trivial property but not the person of his daughter.

After certification the Attorney General filed as of right (R.2:3-4) a cross-appeal[3.1] challenging the action of the trial court in admitting evidence of prior statements made by Karen while competent as to her distaste for continuance of life by extraordinary medical procedures, under circumstances not unlike those of the present case. These quoted statements were made in the context of several conversations with regard to others terminally ill and being subjected to like heroic measures. The statements were advanced as evidence of what she would want done in such a contingency as now exists. She was said to have firmly evinced her wish, in like circumstances, not to have her life prolonged by the otherwise futile use of extraordinary means. Because we agree with the conception of the trial court that such statements, since they were remote and impersonal, lacked significant probative weight, it is not of consequence to our opinion that we decide whether or not they were admissible hearsay. Again, after certification, the guardian of the person of the incompetent (who had been appointed as a part of the judgment appealed from) resigned and was succeeded by another, but that too seems irrelevant to decision. It is, however, of interest to note the trial court's delineation (in its supplemental opinion of November 12, 1975) of the extent of the persona

3.1 This cross-appeal was later informally withdrawn but in view of the importance of the matter we nevertheless deal with it.

guardian's authority with respect to medical care of his ward:

> Mr. Coburn's appointment is designed to deal with those instances wherein Dr. Morse, in the process of administering care and treatment to Karen Quinlan, feels there should be concurrence on the extent or nature of the care or treatment. If Mr. and Mrs. Quinlan are unable to give concurrence, then Mr. Coburn will be consulted for his concurrence.

Essentially then, appealing to the power of equity, and relying on claimed constitutional rights of free exercise of religion, of privacy and of protection against cruel and unusual punishment, Karen Quinlan's father sought judicial authority to withdraw the life-sustaining mechanisms temporarily preserving his daughter's life, and his appointment as guardian of her person to that end. His request was opposed by her doctors, the hospital, the Morris County Prosecutor, the State of New Jersey, and her guardian ad litem.

THE FACTUAL BASE

An understanding of the issues in their basic perspective suggests a brief review of the factual base developed in the testimony and documented in greater detail in the opinion of the trial judge. *In re Quinlan*, 137 *N.J. Super.* 227 (Ch. Div. 1975).

[4] Dr. Robert J. Morse, a neurologist, and Karen's treating physician from the time of her admission to Saint Clare's Hospital on April 24, 1975 (reference was made *supra* to "treating physicians" named as defendants; this term included Dr. Arshad Javed, a highly qualified pulmonary internist, who considers that he manages that phase of Karen's care with primary responsibility to the "attending physician," Dr. Morse).

On the night of April 15, 1975, for reasons still unclear, Karen Quinlan ceased breathing for at least two 15 minute periods. She received some ineffectual mouth-to-mouth resuscitation from friends. She was taken by ambulance to Newton Memorial Hospital. There she had a temperature of 100 degrees, her pupils were unreactive and she was unresponsive even to deep pain. The history at the time of her admission to that hospital was essentially incomplete and uninformative.

Three days later, Dr. Morse examined Karen at the request of the Newton admitting physician, Dr. McGee. He found her comatose with evidence of decortication, a condition relating to derangement of the cortex of the brain causing a physical posture in which the upper extremities are flexed and the lower extremities are extended. She required a respirator to assist her breathing. Dr. Morse was unable to obtain an adequate account of the circumstances and events leading up to Karen's admission to the Newton Hospital. Such initial history or etiology is crucial in neurological diagnosis. Relying as he did upon the Newton Memorial records and his own examination, he concluded that prolonged lack of oxygen in the bloodstream, anoxia, was identified with her condition as he saw it upon first observation.

When she was later transferred to Saint Clare's Hospital she was still unconscious, still on a respirator and a tracheotomy had been performed. On her arrival Dr. Morse conducted extensive and detailed examinations. An electroencephalogram (EEG) measuring electrical rhythm of the brain was performed and Dr. Morse characterized the result as "abnormal but it showed some activity and was consistent with her clinical state." Other significant

neurological tests, including a brain scan, an angiogram, and a lumbar puncture were normal in result. Dr. Morse testified that Karen has been in a state of coma, lack of consciousness, since he began treating her. He explained that there are basically two types of coma, sleep-like unresponsiveness and awake unresponsiveness. Karen was originally in a sleep-like unresponsive condition but soon developed ''sleep-wake'' cycles, apparently a normal improvement for comatose patients occurring within three to four weeks. In the awake cycle she blinks, cries out and does things of that sort but is still totally unaware of anyone or anything around her.

Dr. Morse and other expert physicians who examined her characterized Karen as being in a ''chronic persistent vegetative state.'' Dr. Fred Plum, one of such expert witnesses, defined this as a ''subject who remains with the capacity to maintain the vegetative parts of neurological function but who *** no longer has any cognitive function.''

Dr. Morse, as well as the several other medical and neurological experts who testified in this case, believed with certainty that Karen Quinlan is not ''brain dead.'' They identified the Ad Hoc Committee of Harvard Medical School report (infra) as the ordinary medical standard for determining brain death, and all of them were satisfied that Karen met none of the criteria specified in that report and was therefore not ''brain dead'' within its contemplation.

In this respect it was indicated by Dr. Plum that the brain works in essentially two ways, the vegetative and the sapient. He testified:

We have an internal vegetative regulation

which controls body temperature which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart rate, which controls chewing, swallowing and which controls sleeping and waking. We have a more highly developed brain which is uniquely human which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think. Brain death necessarily must mean the death of both of these functions of the brain, vegetative and the sapient. Therefore, the presence of any function which is regulated or governed or controlled by the deeper parts of the brain which in layman's terms might be considered purely vegetative would mean that the brain is not biologically dead.

Because Karen's neurological condition affects her respiratory ability (the respiratory system being a brain stem function) she requires a respirator to assist her breathing. From the time of her admission to Saint Clare's Hospital Karen has been assisted by an MA-1 respirator, a sophisticated machine which delivers a given volume of air at a certain rate and periodically provides a ''sigh'' volume, a relatively large measured volume of air designed to purge the lungs of excretions. Attempts to ''wean'' her from the respirator were unsuccessful and have been abandoned.

The experts believe that Karen cannot now survive without the assistance of the respirator; that exactly how long she would live without it is unknown; that the strong likelihood is that death

would follow soon after its removal, and that removal would also risk further brain damage and would curtail the assistance the respirator presently provides in warding off infection.

It seemed to be the consensus not only of the treating physicians but also of the several qualified experts who testified in the case, that removal from the respirator would not conform to medical practices, standards and traditions.

The further medical consensus was that Karen in addition to being comatose is in a chronic and persistent "vegetative" state, having no awareness of anything or anyone around her and existing at a primitive reflex level. Although she does have some brain stem function (ineffective for respiration) and has other reactions one normally associates with being alive, such as moving, reacting to light, sound and noxious stimuli, blinking her eyes, and the like, the quality of her feeling impulses is unknown. She grimaces, makes stereotyped cries and sounds and has chewing motions. Her blood pressure is normal.

Karen remains in the intensive care unit at Saint Clare's Hospital, receiving 24-hour care by a team of four nurses characterized, as was the medical attention, as "excellent." She is nourished by feeding by way of a nasal-gastro tube and is routinely examined for infection, which under these circumstances is a serious life threat. The result is that her condition is considered remarkable under the unhappy circumstances involved.

Karen is described as emaciated, having suffered a weight loss of at least 40 pounds, and undergoing a continuing deteriorative process. Her posture is described as fetal-like and grotesque; there is extreme flexion-rigidity of the arms, legs and related

muscles and her joints are severely rigid and deformed.

From all of this evidence, and including the whole testimonial record, several basic findings in the physical area are mandated. Severe brain and associated damage, albeit of uncertain etiology, has left Karen in a chronic and persistent vegetative state. No form of treatment which can cure or improve that condition is known or available. As nearly as may be determined, considering the guarded area of remote uncertainties characteristic of most medical science predictions, she can never be restored to cognitive or sapient life. Even with regard to the vegetative level and improvement therein (if such it may be called) the prognosis is extremely poor and the extent unknown if it should in fact occur.

She is debilitated and moribund and although fairly stable at the time of argument before us (no new information having been filed in the meanwhile in expansion of the record), no physician risked the opinion that she could live more than a year and indeed she may die much earlier. Excellent medical and nursing care so far has been able to ward off the constant threat of infection, to which she is peculiarly susceptible because of the respirator, the tracheal tube and other incidents of care in her vulnerable condition. Her life accordingly is sustained by the respirator and tubal feeding, and removal from the respirator would cause her death soon, although the time cannot be stated with more precision.

The determination of the fact and time of death in past years of medical science was keyed to the action of the heart and blood circulation, in turn dependent upon pulmonary activity, and hence cessation of

these functions spelled out the reality of death.[5]

Developments in medical technology have obfuscated the use of the traditional definition of death. Efforts have been made to define irreversible coma as a new criterion for death, such as by the 1968 report of the Ad Hoc Committee of the Harvard Medical School (the Committee comprising ten physicians, an historian, a lawyer and a theologian), which asserted that:

> From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes; so the obvious criterion of no heart beat as synonymous with death was sufficiently accurate. In those times the heart was considered to be the central organ of the body; it is not surprising that its failure marked the onset of death. This is no longer valid when modern resuscitative and supportive measures are used. These improved activities can now restore "life" as judged by the ancient standards of persistent respiration and continuing heart beat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain damage. ["A Definition of Irreversible Coma," 205 *J.A.M.A.* 337, 339 (1968)].

The Ad Hoc standards, carefully delineated, included absence of response to pain or other stimuli,

[5]Death. The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc. *Black's Law Dictionary* 488 (rev. 4th ed. 1968).

pupillary reflexes, corneal,pharyngeal and other reflexes, blood pressure, spontaneous respiration, as well as "flat" or isoelectric electroencephalograms and the like, with all tests repeated "at least 24 hours later with no change." In such circumstances, where all of such criteria have been met as showing "brain death" the Committee recommends with regard to the respirator:

> The patient's condition can be determined only by a physician. When the patient is hopelessly damaged as defined above, the family and all colleagues who have participated in major decisions concerning the patient, and all nurses involved, should be so informed. Death is to be declared and then the respirator turned off. The decision to do this and the responsibility for it are to be taken by the physician-in-charge, in consultation with one or more physicians who have been directly involved in the case.
>
> It is unsound and undesirable to force the family to make the decision. [205 *J.A.M.A.*, *supra* at 338 (emphasis in original)].

But, as indicated, it was the consensus of medical testimony in the instant case that Karen, for all her disability, met none of these criteria, nor indeed any comparable criteria extant in the medical world and representing, as does the Ad Hoc Committee report, according to the testimony in this case, prevailing and accepted medical standards.

We have adverted to the "brain death" concept and Karen's disassociation with any of its criteria, to emphasize the basis of the medical decision made by Dr. Morse. When plaintiff and his family, finally reconciled to the certainty of Karen's impending

death, requested the withdrawal of life support mechanisms, he demurred. His refusal was based upon his conception of medical standards, practice and ethics described in the medical testimony, such as in the evidence given by another neurologist, Dr. Sidney Diamond, a witness for the State. Dr. Diamond asserted that no physician would have failed to provide respirator support at the outset, and none would interrupt its life-saving course thereafter, except in the case of cerebral death. In the latter case, he thought the respirator would in effect be disconnected from one already dead, entitling the physician under medical standards and, he thought, legal concepts, to terminate the supportive measures. We note Dr. Diamond's distinction of major surgical or transfusion procedures in a terminal case not involving cerebral death, such as here:

> The subject has lost human qualities. It would be incredible, and I think unlikely, that any physician would respond to a sudden hemorrhage, massive hemorrhage or a loss of all her defensive blood cells, by giving her large quantities of blood. I think that *** major surgical procedures would be out of the question even if they were known to be essential for continued physical existence.

This distinction is adverted to also in the testimony of Dr. Julius Korein, a neurologist called by plaintiff. Dr. Korein described a medical practice concept of "judicious neglect" under which the physician will say:

> Don't treat this patient anymore, *** it does

> not serve either the patient, the family, or society in any meaningful way to continue treatment with this patient.

Dr. Korein also told of the unwritten and unspoken standard of medical practice implied in the foreboding initials DNR (do not resuscitate), as applied to the extraordinary terminal case:

> Cancer, metastatic cancer, involving the lungs, the liver, the brain, multiple involvements, the physician may or may not write: Do not resuscitate. *** [I]t could be said to the nurse: if this man stops breathing don't resuscitate him. *** No physician that I know personally is going to try and resuscitate a man riddled with cancer and in agony and he stops breathing. They are not going to put him on a respirator. *** I think that would be the height of misuse of technology.

While the thread of logic is such distinctions may be elusive to the non-medical lay mind, in relation to the supposed imperative to sustain life at all costs, they nevertheless relate to medical decisions, such as the decision of Dr. Morse in the present case. We agree with the trial court that the decision was in accord with Dr. Morse's conception of medical standards and practice.

We turn to that branch of the factual case pertaining to the application for guardianship, as distinguished from the nature of the authorization sought by the applicant. The character and general suitability of Joseph Quinlan as guardian for his daughter, in ordinary circumstances, could not be

doubted. The record bespeaks the high degree of familial love which pervaded the home of Joseph Quinlan and reached out fully to embrace Karen, although she was living elsewhere at the time of her collapse. The proofs showed him to be deeply religious, imbued with a morality so sensitive that months of tortured indecision preceded his belated conclusion (despite earlier moral judgments reached by the other family members, but unexpressed to him in order not to influence him) to seek the termination of life-supportive measures sustaining Karen. A communicant of the Roman Catholic Church, as were other family members, he first sought solace in private prayer looking with confidence, as he says, to the Creator, first for the recovery of Karen and then, if that were not possible, for guidance with respect to the awesome decision confronting him.

To confirm the moral rightness of the decision he was about to make he consulted with his parish priest and later with the Catholic chaplain of Saint Clare's Hospital. He would not, he testified, have sought termination if that act were to be morally wrong or in conflict with the tenets of the religion he so profoundly respects. He was disabused of doubt, however, when the position of the Roman Catholic Church was made known to him as it is reflected in the record in this case. While it is not usual for matters of religious dogma or concepts to enter a civil litigation (except as they may bear upon constitutional right, or sometimes, familial matters; *cf. In re Adoption of E,* 59 *N.J.* 36 (1971)), they were rightly admitted in evidence here. The judge was bound to measure the character and motivations in all respects of Joseph Quinlan as prospective guardian; and insofar as these religious matters

bore upon them, they were properly scrutinized and considered by the court.

Thus germane, we note the position of that Church as illuminated by the record before us. We have no reason to believe that it would be at all discordant with the whole of Judeo-Christian tradition, considering its central respect and reverence for the sanctity of human life. It was in this sense of relevance that we admitted as amicus curiae the New Jersey Catholic Conference, essentially the spokesman for the various Catholic bishops of New Jersey, organized to give witness to spiritual values in public affairs in the statewide community. The position statement of Bishop Lawrence B. Casey, reproduced in the amicus brief, projects these views:

(a) The verification of the fact of death in a particular case cannot be deduced from any religious or moral principle and, under this aspect, does not fall within the competence of the church;--that dependence must be had upon traditional and medical standards, and by these standards Karen Ann Quinlan is assumed to be alive.

(b) The request of plaintiff for authority to terminate a medical procedure characterized as "an extraordinary means of treatment" would not involve euthanasia. This upon the reasoning expressed by Pope Pius XII in his *"allocutio"* (address) to anesthesiologists on November 24, 1957, when he dealt with the question:

> Does the anesthesiologist have the right, or is he bound, in all cases of deep unconsciousness, even in those that are completely hopeless in the opinion of the competent doctor, to use modern artificial respiration apparatus, even against the will

of the family?

His answer made the following points:

1. In ordinary cases the doctor nas the right to act in this manner, but is not bound to do so unless this is the only way of fulfilling another certain moral duty.
2. The doctor, however, has no right independent of the patient. He can act only if the patient explicitly or implicitly, directly or indirectly gives him the permission.
3. The treatment as described in the question constitutes extraordinary means of preserving life and so there is no obligation to use them nor to give the doctor permission to use them.
4. The rights and the duties of the family depend on the presumed will of the unconscious patient if he or she is of legal age, and the family, too, is bound to use only ordinary means.
5. This case is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life, and we must apply in this case the principle of double effect.

So it was that the Bishop Casey statement validated the decision of Joseph Quinlan:

> Competent medical testimony has established that Karen Ann Quinlan has no reasonable hope of recovery from her comatose state by the use of any available medical procedures. The continuance of mechanical (cardiorespiratory) supportive measures to sustain continuation of her body functions and her life constitute extraordinary means of treatment. Therefore, the decision of Joseph Quinlan *** to request the discontinuance of this treatment is, according to the teachings of the Catholic Church, a morally correct decision. (emphasis in original)

And the mind and purpose of the intending guardian were undoubtedly influenced by factors included in the following reference to the interrelationship of the three disciplines of theology, law and medicine as exposed in the Casey statement:

> The right to a natural death is one outstanding area in which the disciplines of theology, medicine and law overlap; or, to put it another way, it is an area in which these three disciplines convene.
>
> Medicine with its combination of advanced technology and professional ethics is both able and inclined to prolong biological life. Law with its felt obligation to protect the life and freedom of the individual seeks to assure each person's right to live out his human life until its natural and inevitable conclusion. Theology with its acknowledgement of man's dissatisfaction with biological life as the ultimate source of joy *** defends the sacredness of human life

and defends it from all direct attacks.

These disciplines do not conflict with one another, but are necessarily conjoined in the application of their principles in a particular instance such as that of Karen Ann Quinlan. Each must in some way acknowledge the other without denying its own competence. The civil law is not expected to assert a belief in eternal life; nor, on the other hand, is it expected to ignore the right of the individual to profess it, and to form and pursue his conscience in accord with that belief. Medical science is not authorized to directly cause natural death; nor, however, is it expected to prevent it when it is inevitable and all hope of a return to an even partial exercise of human life is irreparably lost. Religion is not expected to define biological death; nor, on its part, is it expected to relinquish its responsibility to assist man in the formation and pursuit of a correct conscience as to the acceptance of natural death when science has confirmed its inevitability beyond any hope other than that of preserving biological life in a merely vegetative state.

And the gap in the law is aptly described in the Bishop Casey statement:

> In the present public discussion of the case of Karen Ann Quinlan it has been brought out that responsible people involved in medical care, patients and families have exercised the freedom to terminate or

> withhold certain treatments as extraordinary means in cases judged to be terminal, i.e., cases which hold no realistic hope for some recovery, in accord with the expressed or implied intentions of the patients themselves. To whatever extent this has been happening it has been without sanction in civil law. Those involved in such actions, however, have ethical and theological literature to guide them in their judgments and actions. Furthermore, such actions have not in themselves undermined society's reverence for the lives of sick and dying people.
>
> It is both possible and necessary for society to have laws and ethical standards which provide freedom for decisions, in accord with the expressed or implied intentions of the patient, to terminate or withhold extraordinary treatment in cases which are judged to be hopeless by competent medical authorities, without at the same time leaving an opening for euthanasia. Indeed, to accomplish this, it may simply be required that courts and legislative bodies recognize the present standards and practices of many people engaged in medical care who have been doing what the parents of Karen Ann Quinlan are requesting authorization to have done for their beloved daughter.

Before turning to the legal and constitutional issues involved, we feel it essential to reiterate that the "Catholic view" of religious neutrality in the

circumstances of this case is considered by the Court only in the aspect of its impact upon the conscience, motivation and purpose of the intending guardian, Joseph Quinlan, and not as a precedent in terms of the civil law.

If Joseph Quinlan, for instance,were a follower and strongly influenced by the teachings of Buddha, or if, as an agnostic or atheist, his moral judgments were formed without reference to religious feelings, but were nevertheless formed and viable, we would with equal attention and high respect consider these elements, as bearing upon his character, motivations and purposes as relevant to his qualification and suitability as guardian.

It is from this factual base that the Court confronts and responds to three basic issues:

1. Was the trial court correct in denying the specific relief requested by plaintiff, i.e., authorization for termination of the life-supporting apparatus, on the case presented to him? Our determination on that question is in the affirmative.

2. Was the court correct in withholding letters of guardianship from the plaintiff and appointing in his stead a stranger? On that issue our determination is in the negative.

3. Should this Court, in the light of the foregoing conclusions, grant declaratory relief to the plaintiff? On that question our Court's determination is in the affirmative.

This brings us to a consideration of the constitutional and legal issues underlying the foregoing determinations.

CONSTITUTIONAL AND LEGAL ISSUES

At the outset we note the dual role in which plaintiff comes before the Court. He not only raises, derivatively, what he perceives to be the constitutional and legal rights of his daughter Karen, but he also claims certain rights independently as parent.

Although generally a litigant may assert only his own constitutional rights, we have no doubt that plaintiff has sufficient standing to advance both positions.

While no express constitutional language limits judicial activity to cases and controversies, New Jersey courts will not render advisory opinions or entertain proceedings by plaintiffs who do not have sufficient legal standing to maintain their actions. *Walker v. Stanhope,* 23 *N.J.* 657, 660 (1957). However, as in this case, New Jersey courts commonly grant declaratory relief. Declaratory Judgments Act,*N.J.S.A.*2A:1650 *et seq.* And our courts hold that where the plaintiff is not simply an interloper and the proceeding serves the public interest, standing will be found. *Walker v. Stanhope, supra,* 23 *N.J.* at

661-66; *Koons v. Atlantic City Bd. of Comm'rs*, 135 *N.J.L.* 329, 338-39 (Sup. Ct. 1946), *aff'd*, 135 *N.J.L.* 204 (E. & A. 1947). In *Crescent Park Tenants Ass'n v. Realty Equities Corp.*, 58 *N.J.* 98 (1971), Justice Jacobs said:

> ***[W]e have appropriately confined litigation to those situations where the litigants concerned with the subject matter evidenced a sufficient stake and real adverseness. In the overall we have given due weight to the interests of individual justice, along with the public interest, always bearing in mind that throughout our law we have been sweepingly rejecting procedural frustrations in favor of "just and expeditious determinations on the ultimate merits." [58 *N.J.* at 107-08 (quoting from *Tumarkin v. Friedman*, 17 *N.J. Super.* 20, 21 (App. Div. 1951), certif. den., 9 *N.J.* 287 (1952))]

The father of Karen Quinlan is certainly no stranger to the present controversy. His interests are real and adverse and he raises questions of surpassing importance. Manifestly, he has standing to assert his daughter's constitutional rights, she being incompetent to do so.

I. The Free Exercise of Religion

We think the contention as to interference with religious beliefs or rights may be considered and dealt with without extended discussion, given the acceptance of distinctions so clear and simple in their precedential definition as to be dispositive on their face.

Simply stated, the right to religious beliefs is

absolute but conduct in pursuance thereof is not wholly immune from governmental restraint. *John F. Kennedy Memorial Hosp. v. Heston*, 58 *N.J.* 576, 580-81 (1971). So it is that, for the sake of life, courts sometimes (but not always) order blood transfusions for Jehovah's Witnesses (whose religious beliefs abhor such procedure), *Application of President & Directors of Georgetown College, Inc.*, 331 *F.* 2d 1000 (D.C. Cir.), *cert.* den., 377 *U.S.* 978, 84 *S.Ct.* 1883, 12 *L.Ed.*2d 746 (1964); *United States v. George*, 239 *F. Supp.* 752 (D. Conn. 1965); *John F. Kennedy Memorial Hosp. v. Heston, supra; Powell v. Columbia Presbyterian Medical Center*, 49 *Misc.* 2d 215, 267, *N.Y.S.* 2d 450 (Sup. Ct. 1965); *but see In re Osborne*, 294 *A.* 2d 372 (D.C. Ct. App. 1972); *In re Estate of Brooks*, 32 *Ill.* 2d 361, 205 *N.E.* 2d 435 (Sup. Ct. 1965); *Erickson v. Dilgard*, 44 *Misc.* 2d 27, 252 *N.Y.S.* 2d 705 (Sup. Ct. 1962); *see generally* Annot., "Power Of Courts Or Other Public Agencies, In The Absence Of Statutory Authority, To Order Compulsory Medical Care for Adult," 9 *A.L.R.* 3d 1391 (1966); forbid exposure to death from handling virulent snakes or ingesting poison (interfering with deeply held religious sentiments in such regard), *e.g.*, *Hill v. State*, 38 *Ala. App.* 404, 88 *So.* 2d 880 (Ct. App.), *cert.* den., 264 *Ala.* 697, 88 *So.* 2d 887 (Sup. Ct. 1956); *State v. Massey*, 229 *N.C.* 734, 51 *S.E.* 2d 179 (Sup. Ct.), appeal dismissed *sub nom.*, *Bunn v. North Carolina*, 336 *U.S.* 942, 69 *S.Ct.* 813, 93 *L.Ed.* 1099 (1949); *State ex rel. Swann v. Pack*, *—Tenn.* —, 527 *S.W.* 2d 99 (Sup. Ct. 1975), *cert.* den., — *U.S.*—, — *S.Ct.* —, — *L.Ed.* 2d — (44 *U.S.L.W.* 3498, No. 95-956, (March 8, 1976)); and protect the public health as in the case of compulsory vaccination (over the strongest of

religious objections), *e.g., Wright v. DeWitt School Dist.* 1, 238 *Ark.* 906, 385 *S.W.* 2d 644 (Sup. Ct. 1965); *Mountain Lakes Bd. of Educ. v. Maas,* 56 *N.J.Super.* 245 (App. Div. 1959), *aff'd* o.b., 31 *N.J.* 537 (1960), *cert.* den., 363 *U.S.* 843, 80 *S.Ct.* 1613, 4 *L.Ed.* 2d 1727 (1960); *McCartney v. Austin,* 57 *Misc.* 2d 525, 293 *N.Y.S.* 2d 188 (Sup. Ct. 1968). The public interest is thus considered paramount, without essential dissolution of respect for religious beliefs.

We think, without further examples, that, ranged against the State's interest in the preservation of life, the impingement of religious belief, much less religious "neutrality" as here, does not reflect a constitutional question, in the circumstances at least of the case presently before the Court. Moreover, like the trial court, we do not recognize an independent parental right of religious freedom to support the relief requested. 137 *N.J. Super.* at 267-68.

II. Cruel and Unusual Punishment

Similarly inapplicable to the case before us is the Constitution's Eighth Amendment protection against cruel and unusual punishment which, as held by the trial court, is not relevant to situations other than the imposition of penal sanctions. Historic in nature, it stemmed from punitive excesses in the infliction of criminal penalties.[6] We find no precedent in law

[6]It is generally agreed that the Eighth Amendment's provision of "[n]or cruel and unusual punishments inflicted" is drawn verbatim from the English Declaration of Rights. *See* 1 Wm. & M., sess. 2, c. 2 (1689). The prohibition arose in the context of excessive punishments for crimes, punishments that were barbarous and savage as well as disproportionate to the offense committed. *See generally* Granucci "'Nor Cruel and Unusual Punishments Inflicted:' The Original Meaning," 57 *Calif. L. Rev.* 839, 844-60

which would justify its extension to the correction of social injustice or hardship, such as, for instance, in the case of poverty. The latter often condemns the poor and deprived to horrendous living conditions which could certainly be described in the abstract as "cruel and unusual punishment." Yet the constitutional base of protection from "cruel and unusual punishment" is plainly irrelevant to such societal ills which must be remedied, if at all, under other concepts of constitutional and civil right.

So it is in the case of the unfortunate Karen Quinlan. Neither the State, nor the law, but the accident of fate and nature, has inflicted upon her conditions which though in essence cruel and most unusual, yet do not amount to "punishment" in any constitutional sense.

Neither the judgment of the court below, nor the medical decision which confronted it, nor the law and

Cont.#6

(1969); Note, "The Cruel and Unusual Punishment Clause and the Substantive Criminal Law," 79 *Harv. L. Rev.* 635, 636-39 (1966). The principle against excessiveness in criminal punishments can be traced back to Chapters 20-22 of the *Magna Carta* (1215). The historical background of the Eighth Amendment was examined at some length in various opinions in *Furman v. Georgia,* 408 *U.S.* 238, 92 *S.Ct.* 2726, 33 *L.Ed.* 2d 345 (1972).

The Consitution itself is silent as to the meaning of the word "punishment." Whether it refers to the variety of legal and nonlegal penalties that human beings endure or whether it must be in connection with a criminal rather than a civil proceeding is not stated in the document. But the origins of the clause are clear. And the cases construing it have consistently held that the "punishment" contemplated by the Eighth Amendment is the penalty inflicted by a court for the commission of a crime or in the enforcement of what is a criminal law. *See, e.g., Trop v. Dulles,* 356 *U.S.* 86, 94-99, 78 *S.Ct.* 590, 594-97, 2 *L.Ed.* 2d 630, 638-41 (1957). *See generally* Note, "The Effectiveness of the Eighth Amendment: An Appraisal of Cruel and Unusual Punishment," 36 *N.Y.U.L. Rev.* 846, 854-57 (1961). A deprivation, forfeiture or penalty arising out of a civil proceeding or otherwise cannot be "cruel and unusual punishment" within the meaning of the constitutional clause.

equity perceptions which impelled its action, nor the whole factual base upon which it was predicated, inflicted "cruel and unusual punishment" in the the constitutional sense.

III. The Right of Privacy [7]

It is the issue of the constitutional right of privacy that has given us most concern, in the exceptional circumstances of this case. Here a loving parent, qua parent and raising the rights of his incompetent and profoundly damaged daughter, probably irreversibly doomed to no more than a biologically vegetative remnant of life, is before the court. He seeks authorization to abandon specialized technological procedures which can only maintain for a time a body having no potential for resumption or continuance of other than a "vegetative" existence.

We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus,even if meant the prospect of natural death. To this extent we may distinguish *Heston, supra,* which concerned a severely injured young woman (Delores Heston),

[7]The right we here discuss is included within the class of what have been called rights of "personality." *See* Pound, "Equitable Relief against Defamation and Injuries to Personality," 29 *Harv. L. Rev.* 640, 668-76 (1916). Equitable jurisdiction with respect to the recognition and enforcement of such rights has long been recognized in New Jersey. *See, e. g., Vanderbilt v. Mitchell,* 72 *N.J. Eq.* 910, 919-20 (E. & A. 1907).

whose life depended on surgery and blood transfusion; and who was in such extreme shock that she was unable to express an informed choice (although the Court apparently considered the case as if the patient's own religious decision to resist transfusion were at stake), but most importantly a patient apparently salvable to long life and vibrant health;--a situation not at all like the present case.

We have no hesitancy in deciding, in the instant diametrically opposite case, that no external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life. We perceive no thread of logic distinguishing between such a choice on Karen's part and a similar choice which, under the evidence in this case, could be made by a competent patient terminally ill, riddled by cancer and suffering great pain; such a patient would not be resuscitated or put on a respirator in the example described by Dr. Korein, and a fortiori would not be kept against his will on a respirator.

Although the Constitution does not explicitly mention a right of privacy, Supreme Court decisions have recognized that a right of personal privacy exists and that certain areas of privacy are guaranteed under the Constitution. *Eisenstadt v. Baird.* 405 *U.S.* 438, 92 *S.Ct.* 1029, 31 *L.Ed.* 2d 349 (1972); *Stanley v. Georgia,* 394 *U.S.* 557, 89 *S.Ct.* 1243, 22 *L.Ed.* 2d 542 (1969). The Court has interdicted judicial intrusion into many aspects of personal decision, sometimes basing this restraint upon the conception of a limitation of judicial interest and responsibility, such as with regard to

contraception and its relationship to family life and decision. *Griswold v. Connecticut,* 381 *U.S.* 479, 85 *S.Ct.* 1678, 14 *L.Ed.* 2d 510 (1965).

The Court in *Griswold* found the unwritten constitutional right of privacy to exist in the penumbra of specific guarantees of the Bill of Rights "formed by emanations from those guarantees that help give them life and substance." 381 *U.S.* at 484, 85 *S.Ct.* at 1681, 14 *L.Ed.* 2d at 514. Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions. *Roe v. Wade,* 410 *U.S.* 113, 153, 93 *S.Ct.* 705, 727, 35 *L.Ed.* 2d 147, 177 (1973).

Nor is such right of privacy forgotten in the New Jersey Constitution. *N.J. Const.* (1947), Art. 1, par. 1.

The claimed interests of the State in this case are essentially the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment. In this case the doctors say that removing Karen from the respirator will conflict with their professional judgment. The plaintiff answers that Karen's present treatment serves only a maintenance function; that the respirator cannot cure or improve her condition but at best can only prolong her inevitable slow deterioration and death; and that the interests of the patient, as seen by her surrogate, the guardian, must be evaluated by the court as predominant, even in the face of an opinion contra by the present attending physicians. Plaintiff's distinction is significant. The nature of Karen's care

and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. We think that the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor,--she will never resume cognitive life. And the bodily invasion is very great,--she requires 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube.

Our affirmation of Karen's independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight. 137 *N.J. Super.* at 260. Nevertheless we have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it

should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves as for those closest to them. It is for this reason that we determine that Karen's right of privacy may be asserted in her behalf, in this respect, by her guardian and family under the particular circumstances presented by this record.

Regarding Mr. Quinlan's right of privacy, we agree with Judge Muir's conclusion that there is no parental constitutional right that would entitle him to a grant of relief *in propria persona. Id.* at 266. Insofar as a parental right of privacy has been recognized, it has been in the context of determining the rearing of infants and, as Judge Muir put it, involved "continuing life styles." *See Wisconsin v. Yoder,* 406 *U.S.*205, 92 *S.Ct.*1526, 32 *L.Ed.*2d 15 (1972); *Pierce v. Society of Sisters,* 268 *U.S.* 510, 45 *S.Ct.* 571, 69 *L.Ed.* 1070 (1925); *Meyer v. Nebraska,* 262 *U.S.* 390, 43 *S.Ct.* 625, 67 *L.Ed.* 1042 (1923). Karen Quinlan is a 22 year old adult. Her right of privacy in respect of the matter before the Court is to be vindicated by Mr. Quinlan as guardian, as hereinabove determined.

IV. The Medical Factor

Having declared the substantive legal basis upon which plaintiff's rights as representative of Karen

must be deemed predicated, we face and respond to the assertion on behalf of defendants that our premise unwarrantably offends prevailing medical standards. We thus turn to consideration of the medical decision supporting the determination made below, conscious of the paucity of pre-existing legislative and judicial guidance as to the rights and liabilities therein involved.

> A significant problem in any discussion of sensitive medical-legal issues is the marked, perhaps unconscious, tendency of many to distort what the law is, in pursuit of an exposition of what they would like the law to be.
>
> Nowhere is this barrier to the intelligent resolution of legal controversies more obstructive than in the debate over patient rights at the end of life. Judicial refusals to order lifesaving treatment in the face of contrary claims of bodily self-determination or free religious exercise are too often cited in support of a preconceived "right to die," even though the patients, wanting to live, have claimed no such right. Conversely, the assertion of a religious or other objection to lifesaving treatment is at times condemned as attempted suicide, even though suicide means something quite different in the law. [Byrn, "Compulsory Lifesaving Treatment For The Competent Adult," 44 *Fordham L. Rev.* I (1975)].

Perhaps the confusion there adverted to stems from mention by some courts of statutory or common law condemnation of suicide as demonstrating the state's interest in the preservation of life. We would

see, however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death. The contrasting situations mentioned are analogous to those continually faced by the medical profession. When does the institution of life-sustaining procedures, ordinarily mandatory, become the subject of medical discretion in the context of administration to persons in extremis? And when does the withdrawal of such procedures, from such persons already supported by them, come within the orbit of medical discretion? When does a determination as to either of the foregoing contingencies court the hazard of civil or criminal liability on the part of the physician or institution involved?

The existence and nature of the medical dilemma need hardly be discussed at length, portrayed as it is in the present case and complicated as it has recently come to be in view of the dramatic advance of medical technology. The dilemma is there, it is real, it is constantly resolved in accepted medical practice without attention in the courts, it pervades the issues in the very case we here examine. The branch of the dilemma involving the doctor's responsibility and the relationship of the court's duty was thus conceived by Judge Muir:

> Doctors***to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultation with other physicians, must guide their decision-making processes in providing care to their patient. The nature, extent and

> duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from control of the medical profession and place it in the hands of the courts? [137 *N.J. Super.* at 259].

Such notions as to the distribution of responsibility, heretofore generally entertained, should however neither impede this Court in deciding matters clearly justiciable nor preclude a re-examination by the Court as to underlying human values and rights. Determinations as to these must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the Court has a non-delegable judicial responsibility.

Put in another way, the law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of. Where a Karen Quinlan, or a parent, or a doctor, or a hospital, or a State seeks the process and response of a court, it must answer with its most informed conception of justice in the previously unexplored circumstances presented to it. That is its obligation and we are here fulfilling it, for the actors and those having an interest in the matter should not go without remedy.

Courts in the exercise of their parens patriae responsibility to protect those under disability have sometimes implemented medical decisions and authorized their carrying out under the doctrine of "substituted judgment." *Hart v. Brown*, 29 *Conn.*

Super. 368, 289 *A.* 2d 386, 387-88 (Super. Ct. 1972); *Strunk v. Strunk*, 445 *S.W.* 2d 145, 147-48 (Ky. Ct. App. 1969). For as Judge Muir pointed out:

> "As part of the inherent power of equity, a Court of Equity has full and complete jurisdiction over the persons of those who labor under any legal disability***. The Court's action in such a case is not limited by any narrow bounds, but it is empowered to stretch forth its arm in whatever direction its aid and protection may be needed. While this is indeed a special exercise of equity jurisdiction, it is beyond question that by virtue thereof the Court may pass upon purely personal rights." [137 *N.J. Super.* at 254 (quoting from *Am. Jur.* 2d, Equity § 69 (1966))].

But insofar as a court, having no inherent medical expertise, is called upon to overrule a professional decision made according to prevailing medical practice and standards, a different question is presented. As mentioned below, a doctor is required

> "to exercise in the treatment of his patient the degree of care, knowledge and skill ordinarily possessed and exercised in similar situation by the average member of the profession practicing in his field." *Schueler v. Strelinger,* 43 *N.J.* 330, 344 (1964). If he is a specialist he "must employ not merely the skill of a general practitioner, but also that special degree of skill normally possessed by the average physician who devotes special study and attention to the particular organ or disease or injury involved, having regard to the present

> state of scientific knowledge." *Clark v. Wichman,* 72 *N.J.Super.* 486, 493 (App. Div. 1962). This is the duty that establishes his legal obligations to his patients. [137 *N.J.Super.* at 257-58].

The medical obligation is related to standards and practice prevailing in the profession. The physicians in charge of the case, as noted above, declined to withdraw the respirator. That decision was consistent with the proofs below as to the then existing medical standards and practices.

Under the law as it then stood, Judge Muir was correct in declining to authorize withdrawal of the respirator.

However, in relation to the matter of the declaratory relief sought by plaintiff as representative of Karen's interests, we are required to reevaluate the applicability of the medical standards projected in the court below. The question is whether there is such internal consistency and rationality in the application of such standards as should warrant their constituting an ineluctable bar to the effectuation of substantive relief for plaintiff at the hands of the court. We have concluded not.

In regard to the foregoing it is pertinent that we consider the impact on the standards both of the civil and criminal law as to medical liability and the new technological means of sustaining life irreversibly damaged.

The modern proliferation of substantial malpractice litigation and the less frequent but even more unnerving possibility of criminal sanctions would seem, for it is beyond human nature to suppose otherwise, to have bearing on the practice

and standards as they exist. The brooding presence of such possible liability, it was testified here, had no part in the decision of the treating physicians. As did Judge Muir, we afford this testimony full credence. But we cannot believe that the stated factor has not had a strong influence on the standards, as the literature on the subject plainly reveals. (See footnote 8, *infra*). Moreover our attention is drawn not so much to the recognition by Drs. Morse and Javed of the extant practice and standards but to the widening ambiguity of those standards themselves in their application to the medical problems we are discussing.

The agitation of the medical community in the face of modern life prolongation technology and its search for definitive policy are demonstrated in the large volume of relevant professional commentary.[8]

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[8] *See, e.g., Downing, Euthanasia and the Right to Death* (1969); *St. John-Stevas, Life, Death and the Law* (1961); *Williams, The Sanctity of Human Life and the Criminal Law* (1957); Appel, "Ethical and Legal Questions Posed by Recent Advances in Medicine," 205 *J.A.M.A.* 513 (1968); Cantor, "A Patient's Decision To Decline Life-Saving Medical Treatment: Bodily Integrity Versus The Preservation Of Life," 26 *Rutgers L. Rev.* 228 (1973); Claypool, "The Family Deals with Death," 27 *Baylor L. Rev.* 34 (1975); Elkington, "The Dying Patient, The Doctor and The Law," 13 *Vill. L. Rev.* 740 (1968); Fletcher, "Legal Aspects of the Decision Not to Prolong Life," 203 *J.A.M.A.* 65 (1968); Foreman, "The Physician's Criminal Liability for the Practice of Euthanasia," 27 *Baylor L. Rev.* 54 (1975); Gurney, "Is There A Right To Die?--A Study of the Law of Euthanasia," 3 *Cumb.-Sam. L. Rev.* 235 (1972); Mannes, "Euthanasia vs. The Right To Life," 27 *Baylor L. Rev.* 68 (1975); Sharp & Crofts, "Death with Dignity and The Physician's Civil Liability," 27 *Baylor L. Rev.* 86 (1975); Sharpe & Hargest, "Lifesaving Treatment for Unwilling Patients," 36 *Fordham L. Rev.* 695 (1968); Skegg, "Irreversibly Comatose Individuals: 'Alive' or 'Dead'?," 33 *Camb. L.J.* 130 (1974); Comment, "The Right to Die," 7 *Houston L. Rev.* 654 (1970); Note, "The Time Of Death--A Legal, Ethical and Medical Dilemma," 18 *Catholic Law.* 243 (1972); Note, "Compulsory Medical Treatment: The State's Interest Re-evaluated," 51 *Minn. L. Rev.* 293 (1966).

The wide debate thus reflected contrasts with the relative paucity of legislative and judicial guides and standards in the same field. The medical profession has sought to devise guidelines such as the "brain death" concept of the Harvard Ad Hoc Committee mentioned above. But it is perfectly apparent from the testimony we have quoted of Dr. Korein, and indeed so clear as almost to be judicially noticeable, that humane decisions against resuscitative or maintenance therapy are frequently a recognized de facto response in the medical world to the irreversible, terminal, pain-ridden patient, especially with familial consent. And these cases, of course, are far short of "brain death."

We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable. In this sense, as we were reminded by the testimony of Drs. Korein and Diamond, many of them have refused to inflict an undesired prolongation of the process of dying on a patient in irreversibl condition when it is clear that such "therapy offers neither human nor humane benefit. We think these attitudes represent a balanced implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the whole Judeo-Christian tradition of regard for human life. No less would they seem consistent with the moral matrix of medicine, "to heal," very much in the sense of the endless mission of the law, "to do justice."

Yet this balance, we feel, is particularly difficult to perceive and apply in the context of the development by advanced technology of sophisticated and artificial life-sustaining devices. For those possibly curable, such devices are of great value, and, as ordinary medical procedures, are essential. Consequently, as pointed out by Dr. Diamond, they are necessary because of the ethic of medical practice. But in light of the situation in the present case (while the record here is somewhat hazy in distinguishing between "ordinary" and "extraordinary" measures), one would have to think that the use of the same respirator or like support could be considered "ordinary" in the context of the possibly curable patient but "extraordinary" in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient. And this dilemma is sharpened in the face of the malpractice and criminal action threat which we have mentioned.

We would hesitate, in this imperfect world, to propose as to physicians that type of immunity which from early common law has surrounded judges and grand jurors, *see, e.g., Grove v Van Duyn*, 44 *N.J.L.* 654, 656-57 (E. & A. 1882); *O'Regan v. Schermerhorn*, 25 *N.J. Misc.* 1, 19-20 (Sup. Ct. 1940), so that they might without fear of personal retaliation perform their judicial duties with independent objectivity. In *Bradley v. Fisher*, 80 *U.S.* (13 *Wall.*) 335, 347, 20 *L.Ed.* 646, 649 (1872), the Supreme Court held:

> [I]t is a general principle of the highest importance to the proper administration of justice that a judicial officer, in exercising the authority

> vested in him, shall be free to act upon his own convictions, without apprehension of personal consequences to himself.

Lord Coke said of judges that "they are only to make an account to God and the King [the State]." 12 *Coke Rep.* 23, 25, 77 *Eng. Rep.* 1305, 1307 (S.C. 1608).

Nevertheless, there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.

A technique aimed at the underlying difficulty (though in a somewhat broader context) is described by Dr. Karen Teel, a pediatrician and a director of Pediatric Education, who writes in the *Baylor Law Review* under the title "The Physician's Dilemma: A Doctor's View: What The Law Should Be." Dr. Teel recalls:

> Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make. We are not always morally and legally authorized to make them. The physician is thereby assuming a civil and criminal liability that, as often as not, he does not even realize as a factor in his decision. There is little or no dialogue in this whole process. The

physician assumes that his judgment is called for and, in good faith, he acts. Someone must and it has been the physician who has assumed the responsibility and the risk.

I suggest that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared. Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians, *** which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers. Generally, the authority of these committees is primarily restricted to the hospital setting and their official status is more that of an advisory body than of an enforcing body.

The concept of an Ethics Committee which has this kind of organization and is readily accessible to those persons rendering medical care to patients, would be, I think, the most promising direction for further study at this point. ***

*** [This would allow] some much needed dialogue regarding these issues and [force] the point of exploring all of the options for a particular patient. It diffuses the responsibility for making these judgments. Many physicians, in many circumstances, would welcome this sharing of responsibility.

I believe that such an entity could lend itself well to an assumption of a legal status which would allow courses of action not now

undertaken because of the concern for liability. [27 *Baylor L. Rev.* 6, 8-9 (1975)].

The most appealing factor in the technique suggested by Dr. Teel seems to us to be the diffusion of professional responsibility for decision, comparable in a way to the value of multi-judge courts in finally resolving on appeal difficult questions of law. Moreover, such a system would be protective to the hospital as well as the doctor in screening out, so to speak, a case which might be contaminated by less than worthy motivations of family or physician. In the real world and in relationship to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent.

We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome. Such a requirement is distinguishable from the judicial overview fraditionally required in other matters such as the adjudication and commitment of mental incompetents. This is not to say that in the case of an otherwise justiciable controversy access to the courts would be foreclosed; we speak rather of a general practice and procedure.

And although the deliberations and decisions which we describe would be professional in nature they should obviously include at some stage the feelings of the family of an incompetent relative. Decision-making within health care if it is considered as an expression of a primary obligation of the

physician, primum non nocere, should be controlled primarily within the patient-doctor-family relationship, as indeed was recognized by Judge Muir in his supplemental opinion of November 12, 1975.

If there could be created not necessarily this particular system but some reasonable counterpart, we would have no doubt that such decisions, thus determined to be in accordance with medical practice and prevailing standards, would be accepted by society and by the courts, at least in cases comparable to that of Karen Quinlan.

The evidence in this case convinces us that the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed.

In summary of the present Point of this opinion, we conclude that the state of the pertinent medical standards and practices which guided the attending physicians in this matter is not such as would justify this Court in deeming itself bound or controlled thereby in responding to the case for declaratory relief established by the parties on the record before us.

V. Alleged Criminal Liability

Having concluded that there is a right of privacy that might permit termination of treatment in the circumstances of this case, we turn to consider the relationship of the exercise of that right to the criminal law. We are aware that such termination of treatment would accelerate Karen's death. The County Prosecutor and the Attorney General maintain that there would be criminal liability for such acceleration. Under the statutes of this State, the unlawful killing of another human being is

criminal homicide. *N.J.S.A.* 2A:113-1, 2, 5. We conclude that there would be no criminal homicide in the circumstances of this case. We believe, first, that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.

These conclusions rest upon definitional and constitutional bases. The termination of treatment pursuant to the right of privacy is, within the limitations of this case, ipso facto lawful. Thus, a death resulting from such an act would not come within the scope of the homicide statutes proscribing only the unlawful killing of another. There is a real and in this case determinative distinction between the unlawful taking of the life another and the ending of artificial life-support systems as a matter of self-determination.

Furthermore, the exercise of a constitutional right such as we have here found is protected from criminal prosecution. *See Stanley v. Georgia, supra,* 394 *U.S.* at 559, 89 *S.Ct.* at 1245, 22 *L.Ed.* 2d at 546. We do not question the State's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy. *See id.* at 568, 89 *S.Ct.* at 1250, 22 *L.Ed.* 2d at 551. The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime. *Eisenstadt v. Baird, supra,* 405 *U.S.* at 445-46, 92 *S.Ct.* at 1034-35, 31 *L.Ed.* 2d at 357-58; *Griswold v. Connecticut, supra,* 381 *U.S.* at 481, 85

S.Ct. at 1679-80, 14 *L.Ed.* 2d at 512-13. And, under the circumstances of this case, these same principles would apply to and negate a valid prosecution for attempted suicide were there still such a crime in this State.[9]

VI. The Guardianship of the Person

The trial judge bifurcated the guardianship, as we have noted, refusing to appoint Joseph Quinlan to be guardian of the person and limiting his guardianship to that of the property of his daughter. Such occasional division of guardianship, as between responsibility for the person and the property of an incompetent person, has roots deep in the common law and was well within the jurisdictional capacity of the trial judge. *In re Rollins,* 65 *A.* 2d 667, 679-82 (N.J. Cty. Ct. 1949).

The statute creates an initial presumption of entitlement to guardianship in the next of kin, for it provides:

> In any case where a guardian is to be appointed, letters of guardianship shall be granted *** to the next of kin, or if *** it is proven to the court that no appointment from among them will be to the best interest of the

9 An attempt to commit suicide was an indictable offense at common law and as such was indictable in this State as a common law misdemeanor. 1 *Schlosser, Criminal Laws of New Jersey* § 12.5 (3d ed. 1970); *see N.J.S.A.* 2A:85-1. The legislature downgraded the offense in 1957 to the status of a disorderly persons offense, which is not a "crime" under our law. *N.J.S.A.* 2A:170-25.6. And in 1971, the legislature repealed all criminal sanctions for attempted suicide. *N.J.S.A.* 2A:85-5.1. Provision is now made for temporary hospitalization of persons making such an attempt. *N.J.S.A.* 30:4-26.3a. We note that under the proposed New Jersey Penal Code (Oct. 1971) there is no provision for criminal punishment of attempted suicide. *See* Commentary, § 2C:11-6. There is, however, an independent offense of "aiding suicide." § 2C:11-6b. This provision, if enacted, would not be incriminatory in circumstances similar to those presented in this case.

> incompetent or his estate, then to such other proper person as will accept the same. [*N.J.S.A.* 3A:6-36. *See In re Roll,* 117 *N.J. Super.* 122,124 (App. Div. 1971)].

The trial court was apparently convinced of the high character of Joseph Quinlan and his general suitability as guardian under other circumstances, describing him as "very sincere, moral, ethical and religious." The court felt, however, that the obligation to concur in the medical care and treatment of his daughter would be a source of anguish to him and would distort his "decision-making processes." We disagree, for we sense from the whole record before us that while Mr. Quinlan feels a natural grief, and understandably sorrows because of the tragedy which has befallen his daughter, his strength of purpose and character far outweighs these sentiments and qualifies him eminently for guardianship of the person as well as the property of his daughter. Hence we discern no valid reason to overrule the statutory intendment of preference to the next of kin.

DECLARATORY RELIEF

We thus arrive at the formulation of the declaratory relief which we have concluded is appropriate to this case. Some time has passed since Karen's physical and mental condition was described to the Court. At that time her continuing deterioration was plainly projected. Since the record has not been expanded we assume that she is now even more fragile and nearer to death than she was then. Since her present treating physicians may give

reconsideration to her present posture in the light of this opinion, and since we are transferring to the plaintiff as guardian the choice of the attending physician and therefore other physicians may be in charge of the case who may take a different view from that of the present attending physicians, we herewith declare the following affirmative relief on behalf of the plaintiff. Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.[10] We herewith specifically so hold.

CONCLUSION

We therefore remand this record to the trial court to implement (without further testimonial hearing) the following decisions:

1. To discharge, with the thanks of the Court for

[10] The declaratory relief we here award is not intended to imply that the principles enunciated in this case might not be applicable in divers other types of terminal medical situations such as those described by Drs. Korein and Diamond, *supra*, not necessarily involving the hopeless loss of cognitive or sapient life.

his service, the present guardian of the person of Karen Quinlan, Thomas R. Curtin, Esquire, a member of the Bar and an officer of the court.

2. To appoint Joseph Quinlan as guardian of the person of Karen Quinlan with full power to make decisions with regard to the identity of her treating physicians.

We repeat for the sake of emphasis and clarity that upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor, on the part of any participant, whether guardian, physician, hospital or others.

By the above ruling we do not intend to be understood as implying that a proceeding for judicial declaratory relief is necessarily required for the implementation of comparable decisions in the field of medical practice.

Modified and remanded.

C-1

SUPREME COURT OF NEW JERSEY
M - 1034 SEPTEMBER TERM 1975

IN THE MATTER OF KAREN QUINLAN
AN ALLEGED INCOMPETENT

O R D E R

This matter having been duly presented to the Court, it is ORDERED that the application of Stephen Garger and Richard Gallagher for the issuance of an order to show cause denied.

WITNESS, the Honorable Richard J. Hughes, Chief Justice, at Trenton, this 1st day of June, 1976.

/S/ Florence R. Poskoe
Clerk

FILED
JUNE 1 1976
FLORENCE R. POSKOE
CLERK

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ROBERT MUIR, JR., J.S.C.
Copy of this pleading
retained in the
Morris County Clerk's Office

PAUL M. ARMSTRONG, ESQUIRE
801 Lindsley Drive
Morristown, New Jersey 07960

IN THE MATTER OF KAREN QUINLAN,
AN ALLEGED INCOMPETENT

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION
MORRIS COUNTY

Docket No. C-201-75

Civil Action

ACCEPTANCE OF GUARDIANSHIP
IN ACCORD WITH
SUPREME COURT OPINION

THE PLAINTIFF, JOSEPH THOMAS QUINLAN, residing at 510 Ryerson Road, Landing, New Jersey, being duly sworn according to law, upon his oath deposes and says:

I, having been appointed the guardian of the person and property of my daughter, Karen Quinlan, by an Order entered on April 1, 1976, by Robert Muir, Jr., Judge of the Superior Court Chancery Division - Morris County, do hereby declare my acceptance of said guardianship.

Joseph T. Quinlan

Sworn and subscribed to
before me this 9th
day of April, 1976.

Helena D'Arach
NOTARY PUBLIC OF NEW JERSEY
My Commission Expires Jan. 23, 1978

Joseph T. Quinlan

cc Robert W. Hicks, Esq.
1920 Eye St. N.W.
Washington, DC
20006

ROWE, McMAHON, McKEON & CURTIN
LAW OFFICES
FEDERAL TRUST BUILDING
24 COMMERCE STREET
NEWARK, N.J. 07102

May 28, 1976

Mr. Richard Gallagher, President
Human Life Amendment Group
663 5th Avenue
New York, New York 10022

Re: In the Matter of Karen Ann Quinlan

Dear Mr. Gallagher:

Thank you for your recent letter setting forth your position in that of the Human Life Amendment Group with respect to my role as guardian of the person of Karen Ann Quinlan.

You realize, I am sure that prior to making the decision not to appeal that both Mr. Coburn and I spent many hours in consultation and considered the appeal from every point of view before making our decision not to appeal. We made our decision, not solely on the basis of our personal feelings, our emotions or even our convictions, but rather as lawyers charged with a grave responsibility.

We made the decision not to appeal based upon

certain representations which were made to us as to the care to be afforded Karen. That care was to include the use of standard medical practice as we understood it, and was to include continued care by Doctors Morse and Javed along or in consultation with other physicians whose qualifications we recognized.

As of the date of this letter, Karen has been removed from the respirator. She is still being treated with antibiotics and is still being fed with a special substance called Vio-Dex. While she has been removed from the respirator, she is still being given pure oxygen through the oxygen catheter which is connected to the trachea.

The Supreme Court decision gave Mr. & Mrs. Quinlan the right to select both the physicians and hospital. Now some question has arisen as to the interpretation of that Supreme Court decision, in particular what rights it gave the Quinlan family with respect to the discontinuance of life support systems. The difficulty is in the definition of life support system. The Quinlans contending that it means any system which will support or maintain Karen's life artificially. Mr. Coburn and I following consultation with our experts have concluded that the Supreme Court was referring to the respirator only, and did not contemplate a situation where Karen would not be fed, nor given antibiotics or otherwise treated in accordance with standard medical practice.

Mr. Coburn and I are monitoring the situation, have been in daily contact with the principals of

this litigation and will make any future decisions based upon the day to day developments in this matter.

I have been the recipient of a great deal of mail on the Karen Ann Quinlan matter, some pro and some con, however, this is the first correspondence that I personally have had from any Human Rights organization. I question the timing of this correspondence, as Mr. Coburn and I made our decision over a month ago. Prior to that time, I had not received any mail from your organization or from any other pro-life organization.

It might have been more appropriate for your organization to attempt to intervene in the litigation as the Catholic Council did when it filed an Amicus brief in the New Jersey Supreme Court. Perhaps everyone anticipated this matter going beyond the New Jersey Supreme Court to the United States Supreme Court and intended to make their statement to the court as friend of the court at that time.

It is a difficult area, and it has been further complicated by the lack of information from the Quinlan family and their counsel, although I understand their position with respect to their right to family privacy. As I have said before, Mr. Coburn and I are watching the day to day developments and will act in accordance with our beliefs in what we believe is Karen's best interest.

Thank you for your interest in this matter.

Very truly yours,

/S/ Thomas R. Curtin

TRC:beh

Thomas R. Curtin

SUPERIOR COURT OF NEW JERSEY
MORRIS COUNTY: CHANCERY

June 11, 1976

In the Matter of
KAREN QUINLAN
An Alleged Incompetent

STENOGRAPHIC TRANSCRIPT

BEFORE: HON. ROBERT MUIR, JR. J.S.C.

THE COURT: All right, gentlemen.

This is an application for an Order to Show Cause.

In accordance with my normal procedure, I will not hear any argument. I will state what the application is and I will dispose of it on its face.

I have here an application for an Order to Show Cause, which seeks, and I will quote from it - - "to return Karen Quinlan to St. Clare's Hospital from her present place in the County Welfare Nursing Home and to grant a stay pending Writ of Certiorari to the Supreme Court of the United States - - and it seeks other relief."

Petition is filed in the name of Richard Gallagher and Stephen Garger, ...

"Any procedural steps that you choose to take hereafter and whatever you wish to do, you may do.

Your application for an Order to Show Cause is denied. Mr. Crowley, I will ask you to prepare it - - Mr. Crowley or Mr. Armstrong, I will ask you to prepare the Order denying the application for an Order to Show Cause in accordance with my oral opinion.''

June 11, 1976

/S/ ROBERT MUIR, JR., J.S.C.
Judge Superior Court
of New Jersey

P. S. The Show Cause Order was rejected without comment:

Re: C 201-75 in the matter of KAREN QUINLAN -RICHARD GALLAGHER and STEPHEN GARGER v. NEW JERSEY.

By: /S/ Robert W. Hicks, Esq.

REFERENCE MISCELLANEOUS TEXT

The following self-explanatory collateral reading material was furnished by Robert W. Hicks, admitted to the Bar of this Court, to the Librarian of the Supreme Court of the United States in May of 1976.

Such contributory pertinent data was for the expressed benefit of future research scholars pertaining to the listed subjects, namely;

Ready Reference Material

1 - A DEFINITION OF IRREVERSIBLE COMA.

Complete report of the Ad Hoc Committee of the Harvard Medical School to examine the definition of ''Brain Death'' dated August 5, 1968.

2 - A STATUTORY DEFINITION OF THE STANDARDS FOR DETERMINING HUMAN DEATH: AN APPRAISAL AND A PROPOSAL.

Note: With voluminous footnotes from Volume 121, November 1972 - University of Pennsylvania.

3 - (The Public Printer's ''galley proof'' was furnished because the text had not been printed for distribution).

U.S. SENATE SUBCOMMITTEE HEARING ON HEALTH :

Examination of the Various Moral, Ethical and Legal questions involved in the effort to provide more extraordinary health care and protection of human subjects:

SETTING LIMITS TO SURVIVAL:
INSTITUTE OF SOCIETY, ETHICS AND
LIFE SCIENCES, Washington, D.C.

SUMMARY OF ACTION TAKEN BY THE "HOUSE OF DELEGATES"

Be it resolved, that the "AMERICAN BAR ASSOCIATION" adopts a current definition of death as follows:

> "For all legal purposes, a human body with irreversible cessation of total brain function, according to usual and customary standard of medical practice, shall be considered dead."

Robert W. Hicks, Ph.D.
Washington, D.C.

P.S. In November of 1975, as a result of my technical medical research as a Registered Biomedical Professional Engineer, I embodied a treatise of a methodical discussion of the facts and principles in perceptible form the subject of "Brain Deaths."

I thereby furnished a copy of all the above listed medical research materials to the "NATIONAL LIBRARY OF OF MEDICINE," Department of Health, Education, and Welfare, Public Health, Washington, D.C.

R.W.H.